Career & Technology Studies

Home Care 1
CMH 1060

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Community Health 1060
Home Care 1
Student Module Booklet
Learning Technologies Branch
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This document is intended for	
Students	✓
Teachers	✓
Administrators	
Home Instructors	
General Public	
Other	

You may find the following Internet sites useful:

- Alberta Learning, **http://www.learning.gov.ab.ca**
- Learning Technologies Branch, **http://www.learning.gov.ab.ca/ltb**
- Learning Resources Centre, **http://www.lrc.learning.gov.ab.ca**

The use of the Internet is optional. Exploring the electronic information superhighway can be educational and entertaining. However, be aware that these computer networks are not censored. Students may unintentionally or purposely find articles on the Internet that may be offensive or inappropriate. As well, the sources of information are not always cited and the content may not be accurate. Therefore, students may wish to confirm facts with a second source.

Welcome!

Welcome to CMH 1060.

We hope you'll enjoy your study of
Home Care 1.

CTS strands were designed to stand alone or be integrated with other strands for a customized course of studies to meet student needs. Through each strand, CTS basic competencies (knowledge, skills, and attitudes) will be identified as follows:

Careers: identify appropriate career linkages within the strand being studied

Communication: effectively present concise written, visual, and oral communications

Ethics: make judgements about whether behaviour is right or wrong on personal, community, and global levels

Innovation: recognize opportunities/problems and identify and suggest new ideas

Safety: assess potential risks, and follow personal and environmental safety procedures

Task Management: demonstrate an ability to locate and use resources and to use time effectively

Teamwork: work towards goals co-operatively, collaboratively, or independently, and acknowledge the opinions of others

Technology: effectively use technology when required

These basic competencies build daily living skills useful in a broad range of future endeavours and careers.

The eight icons that appear here indicate to students and facilitators that a basic competency has been identified in the activity offered to the students. Not all of the icons appear in each course.

Resources

Mandatory Resources

In order to complete Community Health 1060, you'll need the following resources:

- a notebook or binder in which to respond to the questions asked in this Student Module Booklet
- a library or some other source of information on home care
- access, by telephone or direct contact, with resources in your community related to community health

Optional Resources

- a computer connected to the Internet
- a VCR (if you're taking this course in a classroom setting)

Visual Cues

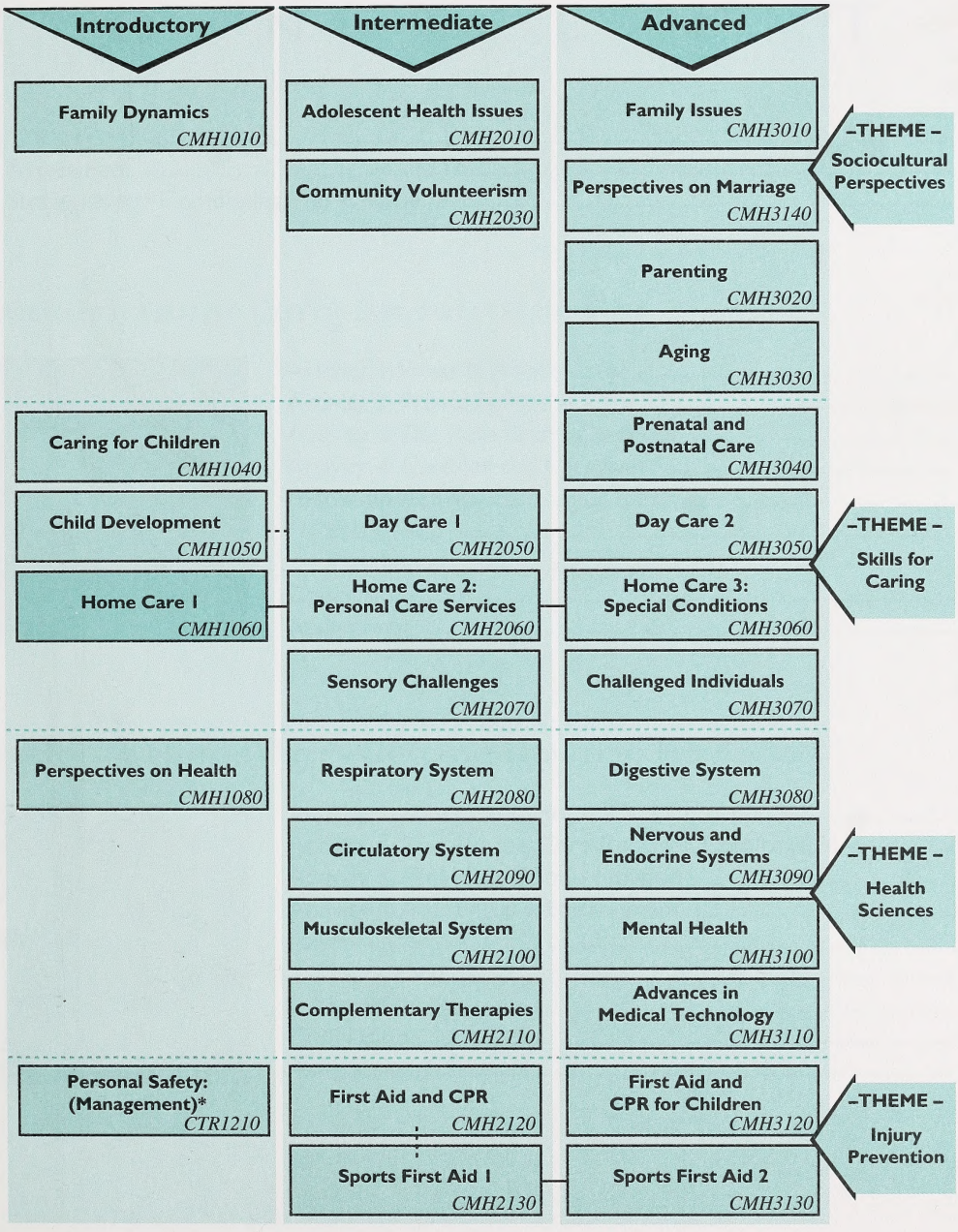
In addition to the Career and Technology basic competencies icons described earlier, you may find visual cues throughout the Student Module Booklet to assist you in your studies. Read the following explanation to discover what the icon prompts you to do.

Access the Internet (always an optional task).

Remember that any Internet website address given in this course is subject to change.

Community Health

O • V • E • R • V • I • E • W



— Prerequisite --- Recommended sequence * Course is also offered in Career Transitions

Some of these courses may not yet be in a distance learning format.

C • O • N • T • E • N • T • S

Section 3: The Skin—The Body's Largest Organ

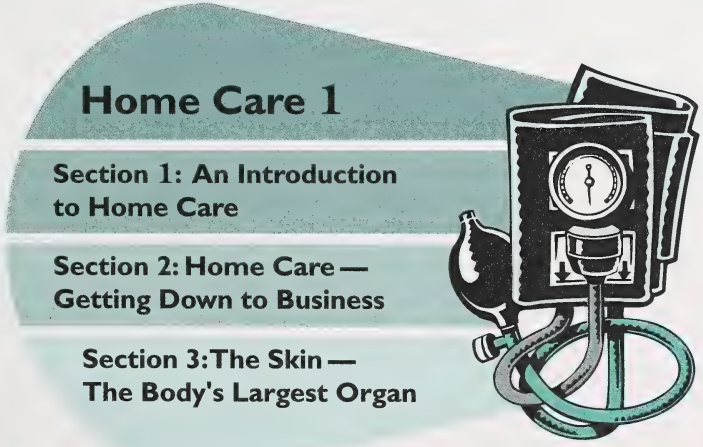
Home Care 1

O • V • E • R • V • I • E • W

magine that your great-grandmother is no longer able to look after herself, and she moves into ur home. You and the other members of your family find yourselves in a new role—that of regivers in a home-care situation. At first, you feel like locking yourself in your room all day and ping your great-grandmother gets better. Gradually, however, you begin to help your parents care r the new member of the household.

u start with small chores. You help your great-grandmother get a sip of water, or find her an extra anket, and you begin to get a real sense of accomplishment from this. You find yourself watching refully as the home-care nurse helps your great-grandmother move around. As the nurse takes her ood pressure and pulse, you realize you can learn a lot. You even begin to think that perhaps you ight like to become a home-care nurse someday.

is course will introduce you to the idea of home care and help you understand the role of regiver. The focus of this course will be on the role of the caregiver in the home rather than that of ofessionals in home care. However, if you're thinking of a career in this area, it will give you a good ounding before going on to Home Care 2 and 3. When you've completed this course, you should be le to explain what home care is, describe the role of the primary caregiver, and identify community sources available for home-care providers. You should also be able to carry out a number of basic me-care procedures and be able to help rearrange a home to accommodate a home-care patient. u should also be capable of discussing the basic care of the human skin—an area of special ncern for home-care providers.



Assessment

The document you are presently reading is called a Student Module Booklet. It will show you, step by step, what to do and how to do it.

This course, Home Care 1, is worth one credit. The course is comprised of three sections. Within each section, your work is grouped into activities. Within the activities, there are readings, explanations, and questions for you to work through. You will correct these activities yourself usin the Appendix at the end of this course. These suggested answers will provide you with immediate feedback on your progress.

A portion of your grade in this course will be based on the assignments that you complete for assessment. There is one assignment after each section. The mark distribution is as follows:

Assignment Booklet A	
Section 1 Assignment	**25 marks**
Section 2 Assignment	**35 marks**
Assignment Booklet B	
Section 3 Assignment	**40 marks**
TOTAL	**100 marks**

CTS courses are competency based, which means that you must successfully complete each section to receive credit for the course.

In addition, you might also be required to complete a final test. The weighting for this final test wil be determined by your teacher.

Strategies for Completing This Course

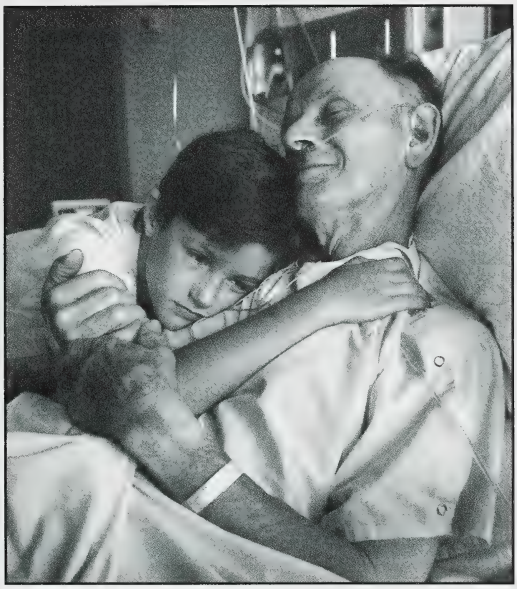
Organize your materials and work area before you begin: Student Module Booklet, notebook, pens pencils, and so on. Make sure you have a quiet area in which to work, away from distractions.

Because response lines are not provided in the Student Module Booklet, you'll need a notebook or lined paper to respond to questions and complete charts. It's important to keep your lined paper handy as you work through the material and to keep your responses together in a notebook or binder for review purposes later.

To achieve success in this course, be sure to read all of the instructions carefully and work slowly and systematically through the material. Remember, it's the work you do in this Student Module Booklet that will prepare you for your assignments. Try to set realistic goals for yourself each day; and when you've set them, stick to them. Do your assignments regularly, and don't forget to review your work before handing it in. Careful work habits will greatly increase your chances for success i Community Health.

Good luck!

An Introduction to Home Care



JIM WHITMER PHOTOGRAPHY

MATTHEW'S Grandpa Carlos had a stroke. He has some speech impairment, mild paralysis in one arm, and is very weak. He is to be discharged from the hospital soon, but he's not able to care for himself in his own home. Matthew thinks his family should look after his grandfather in their home, but his parents realize that this is a big undertaking and that the decision shouldn't be made lightly. It would have a huge impact on their family life.

Matthew's parents have many concerns about their ability to give Grandpa the care he needs. However, they could learn under the supervision of health-care professionals, and with community agencies recommended to them by the hospital staff. Also these agencies could supply them with information and support about home care.

Having to care for family members in the home when they're unable to care for themselves is something that many families must face. This is the issue introduced in this section. When you've finished the section, you should be able to describe the impact that illness can have on a family, explain the rights and responsibilities of those involved in home-care, and identify some of the resources available to people faced with this situation.

SECTION 1

ACTIVITY 1

What Is Home Care?

The Impact of Illness

At some point in your life, either directly or through a member of your family, serious illness is almost certain to affect you. That's not a terribly pleasant thought, but it's a reality everyone must face. It's often how people deal with illness that determines their ability to cope with it. Ironically, it's often other members of the family—the caregivers—who suffer the greatest stress when a family member falls sick.

Caring for an ill or convalescing family member in the home is a situation that people have experienced from the earliest times. However, in recent years, with improved hospital care and an increase in the number of long-term-care facilities, hasn't been quite as commonplace. Nevertheless this is rapidly changing, and the number of families with ill or disabled members being cared for in the home is once again increasing. This trend is bound to continue in the foreseeable future.

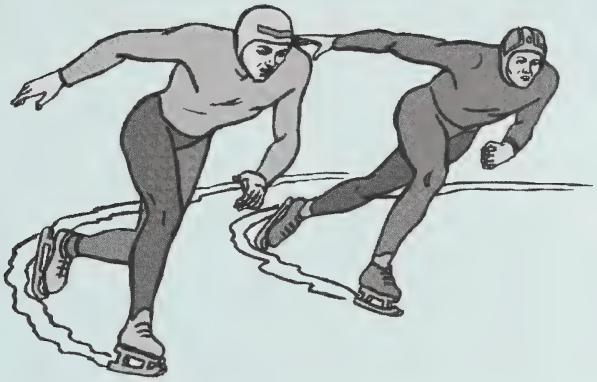
1. Suggest a reason why more people today are finding themselves looking after family members in their homes.

Compare your answer with the one in the Appendix, Section 1: Activity 1.

When a household has a person who is ill or disabled requiring special needs, each member of the household will likely have changes in the normal routine. Some members of the family will acquire special responsiblities and may also need to learn a few new procedures to help out.

Following are three scenarios. Read them over to get an idea of how illness can affect families in different ways.

Scenario 1



Taka Seiko was excited about the possibility of winning a medal in a provincial short-track speed-skating competition. He was leading on the last lap when he lost control on the corner and went crashing into the boards, breaking the tibia in his left leg. After the initial hospital assessment and treatment, he was sent home with his leg in a cast from his thigh to his toes.

Taka was disappointed about the end result of his race. He was also aware that he would require a minimum of three weeks lying in bed and a long time after that, on crutches. For the first few days he enjoyed having his family bring him everything he needed, and he liked staying home from school. However, by the end of the week the novelty of watching television all day began to wane, and Taka became very bored. He missed doing things with his friends and began criticizing his family and arguing with everyone.

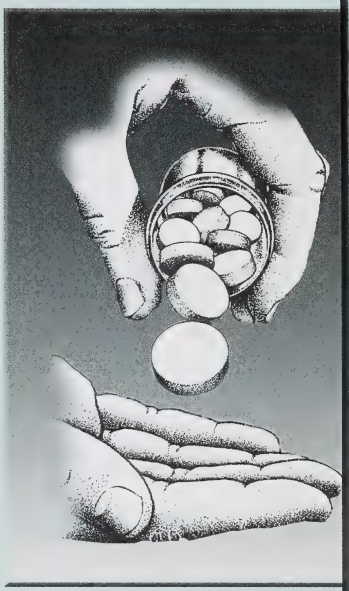
2. a. Why would Taka behave in this way when his family members were doing all they could to look after him?

   b. Explain the effects of Taka's injury on his family.

Compare your answers with those in the Appendix, Section 1: Activity 1.

Scenario 2

Grandpa Carlos, whom you met in the introduction to this section, needs time to recuperate from his stroke. Matthew, his grandson, is excited about having his grandfather to talk to and to play card games with whenever he wants. His parents, however, have many concerns. They realize that Grandpa Carlos feels insecure and doesn't want to be left alone at any time. He needs help getting out of bed to go to the bathroom and has some difficulty eating. He will also need his medications monitored.



At times, Grandpa experiences difficulty breathing, so he needs to have an oxygen supply available and someone to help him use it. He may also require immediate medical attention should another blood clot form causing another stroke.

Also, the room that will make his stay most comfortable and safe happens to be Matthew's; he'll have to sleep in the basement.

3. What impact will it have on the family if the decision is to provide home care for Grandpa Carlos?

Compare your answer with the one in the Appendix, Section 1: Activity 1.

Scenario 3

Mrs. Kquan, a single parent, has fallen 5 metres while at her welding job. She has broken two vertebrae in her neck and one in her lower back. She'll be in hospital at least two months and in rehabilitation for two more. At first, her doctors feared that she would be permanently paralysed, but they're now confident that she should regain a limited use of her limbs.

She is very distressed that she will no longer be able to support her family financially—at least not to the extent that she used to. Also, for quite a while, she won't even be able to share the household responsibilities. She now worries about how her children will get to school and to after-school activities as she's the only member of the family with a driver's licence.

4. Explain the impact Mrs. Kquan's injury will have on her family.

Compare your answer with the one in the Appendix, Section 1: Activity 1.

The Nature of Home Care

The three scenarios you've just read should have you thinking about what home care is. The term **home care** is used to describe situations where individuals who are sick, injured, disabled, or dying, and who are unable to look after themselves, are cared for within the home. The care may be given in the patient's own home, if the condition isn't too severe, or it may be in the home of another person, often a family member.

ne care: *the of people o are sick, red, disabled, ying, and who unable to look r themselves) takes place e home er than in a facility*

Who qualifies for home care? First, the individual must be assessed by a health-care professional to determine if home care is appropriate. This individual may be any age: infant to elderly. Naturally, someone with an **acute** condition that requires the immediate care of doctors, nurses, and sophisticated medical equipment cannot be placed in a home-care setting. A person in this situation needs a hospital. People with **chronic** medical problems, long-term or permanent disabilities, people nearing the end of their lives—people who need the care of others but not the constant attention of health-care professionals—are candidates for home care.

te: *severe, f, critical, and nt*

onic: *lasting ng time*

When people think of home care, they often visualize elderly people like Grandpa Carlos. However home-care recipients can be babies. In fact, children with severe disabilities are frequently looked after by their families; and although there are often many rewards, the constant attention they require can create stressful situations for the family members.

Home-care recipients are sometimes classified into the following three groups:

- people with long-term needs because of a disability or a chronic illness
- people with short-term needs that follow an early discharge from a hospital after an acute illness, an injury, or surgery
- people who are dying and who prefer to face the end of their lives in the familiar surroundings of home and family

People who fit into one of these categories and who are assessed as appropriat home-care candidates by health-care professionals, can qualify for home care. Since, by definition these are people who can't look after themselves, someone have to take over that responsibility. This may be a spouse, a parent, a son or daughter, a grandchild, or some other relative or friend willing to take on the responsibility. This person, called the **primary caregiver** (often referred to as *caregiver*), backed up by doctors, nurses, and other health-care professionals, assume the duties involved in caring for the home-care recipient or *patient.*

primary caregiver: *the person in a household who provides most of the care and assumes the ultimate responsibility for looking after the care receiver*

Taking on the role of primary caregiver in a home-care situation can have a hu impact on a person's life. The activities that follow will give you a better idea of magnitude of that impact, and of the resources available to caregivers to help t successfully manage their new responsibilities.

ACTIVITY 2

Providing Home Care

JIM WHITMER PHOTOGRAPHY

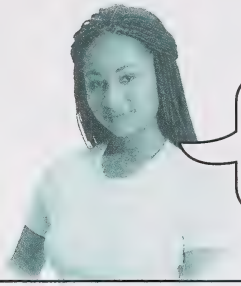
The three scenarios you read at the beginning of Activity 1, along with the introductory discussion of home care that followed them, give you an awareness of how illness or injury in the home can affect family members. Because the impact can be so great and the experience so unexpected, families in this situation often find themselves entirely unprepared. For this reason, organizations such as St. John Ambulance and the Canadian Red Cross have produced publications aimed at helping families cope. Here are a few guidelines from these publications that can help lead to a successful care-giving situation:

- A family must work closely together when dealing with an illness or an injury.
- The family should deal with problems one at a time.
- Everyone has to recognize that adjustments will have to be made.
- Successful home care results when the caregiver is genuinely interested in the care-receiver, understands care giving, and becomes involved in planning the home care.
- Giving good home care means that you must look after the person as well as the illness or injury.
- Complete recovery depends on the attitude of care-receivers as well as on their physical health.
- Caregivers can contribute to a positive attitude by helping care-receivers understand their own behaviour.
- Understanding one's own behaviour leads to success in coping with illness.

1. Do you have any more ideas to add to this list? If you've never been in this situation, think about it seriously and use your imagination. Brainstorm a few ideas with a friend or classmate if you can.

Compare your answer with the one in the Appendix, Section 1: Activity 2.

Good communication is essential for everyone involved in home care. When a family member requires care in the home, both that person and the other family members are likely to experience mixed feelings about the situation. As the home-care experience continues on, people may feel tired, frustrated, angry, and, possibly, overwhelmed. These feelings are natural, and it's important that caregivers and the care-receiver keep the line of communication open and talk about them.



But that isn't always easy. I mean, how can you tell family members—people you love—that you're starting to resent looking after them?

You're right that it can be difficult, but it's important, especially in long-term situations. If those feelings of resentment aren't talked out, they're liable to grow into serious tensions and real anger. In some home-care situations, problems develop to the point where it's necessary to seek professional counselling. Open communications right from the start make this less likely.

Of course, communication is a two-way street. It's important for a caregiver to express personal feelings and to try to understand how the care-receiver is feeling. By allowing time for real discussions and being genuinely sensitive to what is expressed, a caregiver can learn a good deal about the feelings of the care-receiver. By expressing concern and love for the person in care (through a smile, a touch, a hug, or a thoughtful little gift), the care-receiver is reassured that his or her health, happiness, and well-being are important.

Rehabilitation and Diversion

▼

rehabilitation: *the process of restoring to a former state of health and activity*

▲

According to specialists, two aspects should be noted in caregiving: rehabilitation and diversion. **Rehabilitation** is the treatment aimed at halting the destructive process of illness and speeding the repair of the body. Rehabilitation should encourage individuals to live within the limitations imposed by the disability while helping them return as soon as possible to useful or normal activity.

It's important to note that rehabilitation doesn't always involve restoring people to the full range of activities they enjoyed before they were injured or became ill. In some cases, this just isn't possible. In these situations, caregivers should encourage care-receivers to focus on the things they can do–or should one day again be able to do–and not to dwell on those abilities they've lost. As a caregiver, you can encourage rehabilitation by helping an ill person with the exercises and activities recommended by a health-care professional and by encouraging a positive attitude. Caregivers should try to stay enthusiastic, set reasonable, progressive goals each day, be patient, and always show appreciation for whatever progress a care-receiver has made.

Rehabilitation can take a long time. To regain strength, endurance, and former skills, a sick or injured person will have to work gradually and persistently. Time and patience are a must for the caregiver. It's important to keep the recovering person from becoming discouraged, since this only delays the rehabilitation process and perhaps even reduces chances that a significant recovery can be made at all.

2. Health professionals are increasingly becoming more convinced that a positive mental attitude is vitally important for rehabilitation. Magazines and bookstores are full of discussions of this topic. Have you read or heard any of the recent findings or theories on this issue? Or do you know of any real-life examples illustrating the truth of this belief? Explain what you know or have heard in a paragraph or two.

Compare your answer with the one in the Appendix, Section 1: Activity 2.

▼

diversion: *an amusement or pastime that makes the time during illness or convalescence more pleasant*

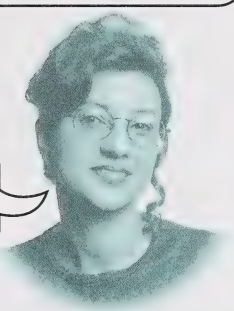
convalescence: *the process or period of recovering health after an illness or injury*

▲

Diversion is making the time during illness or **convalescence** more pleasant. It often involves activities like working on hobbies, reading, or anything that entertains the patient during the recovery period. The key word here is *entertains*; activities intended to help a sick or injured person pass the time must be something that person genuinely enjoys doing within the limits imposed by the illness or injury.

It's very easy for patients to become bored when they are forced to spend many days in bed or confined indoors; this is especially true for active, energetic people. Boredom can lead to restlessness and depression; it allows the ill person time to think about the sickness and worry about not getting well. Feelings like these won't help speed up the recovery process.

I saw on TV the other day how they've found that pets can be really good for people who are in situations like that. The program showed how when patients were allowed to stroke and talk to a dog, for example, their blood pressure went down, they laughed more, they felt better, and their attitude became more positive.



Yes, I've heard about those studies. It's amazing the difference they can make.

3. Imagine that a family member is sick and confined to bed for a lengthy stay (think of a specific individual). Suggest at least **three** activities you, as caregiver, could encourage this person to undertake as a diversion during the recovery period.

Compare your answer with the one in the Appendix, Section 1: Activity 2.

The Terminally Ill Patient

The goals of rehabilitation and diversion are essentially to get the patient well—if possible, to lead an ordinary independent life again. This goal isn't always possible, however. As you discovered in Activity 1, not every home-care patient will get well. Many will suffer with the illness until they die. The caregiver and care-receiver can't look forward to the day when the patient will once again be healthy; instead, the caregiver provides **palliative care**. It is still important for caregivers to provide diversion in situations like this, but they also must come to understand, as much as possible, what the terminally ill patient is going through.

palliative care: *care provided for patients with terminal conditions and intended to alleviate their suffering rather than provide a cure*

According to psychiatrist Dr. Elisabeth Kübler-Ross in her book *On Death and Dying*, people pass through five clearly defined stages in reconciling themselves to dying.

Stage 1: Denial

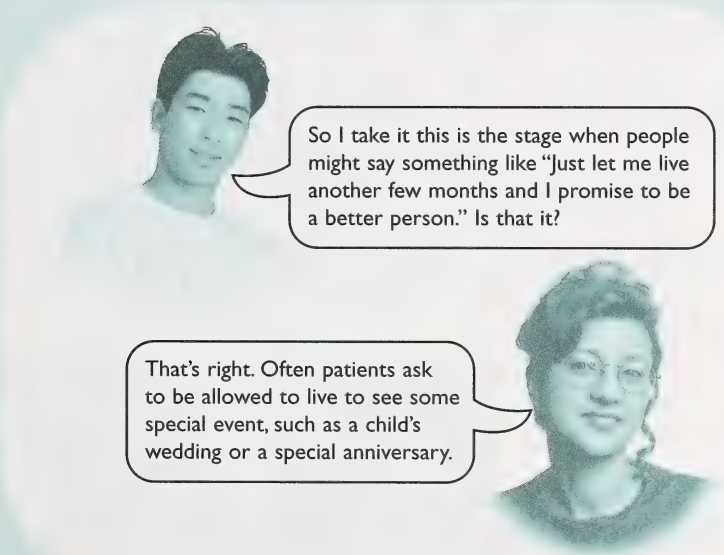
This is the stage where people refuse to accept that they are going to die; the reaction "No, not me!" is typical. This stage is important and necessary as it helps cushion the impact of the patient's awareness that death is inevitable.

Stage 2: Anger

This is when patients move from thinking "No, not me!" to "Why me?" People at this stage of coming to terms with their death will resent the fact that others are going to remain healthy and go on living while they themselves are about to die. Often they look for someone to blame—a doctor, perhaps, or (if they believe in a deity) God. According to Kübler-Ross, anger like this is both permissible and inevitable.

Stage 3: Bargaining

Now patients begin to accept the fact of death, but they try to bargain for more time. For those who believe in God, this can mean trying in their own way to strike a deal with Him. This can be true even with people who aren't religious and have never before prayed or had faith in a supreme being.



Stage 4: Depression

After the bargaining stage, depression generally sets in. Now people facing death will often mourn past losses, things not done, and wrongs committed. They may grow quiet and not want to see visitors. Kübler-Ross maintains that this is a sign that patients are pulling away from the life going on around them. This, she says, is a good sign; it shows that the patients have finished their business with you and can go peacefully. Full acceptance of the inevitable is close.

Stage 5: Acceptance

Finally, the last stage of the process is that of acceptance of death. Kübler-Ross describes this final stage as neither happy nor unhappy. It's devoid of feelings, but that in itself is a victory. Now the patient is free to accept death and leave this world.

Knowledge of Kübler-Ross's five stages can help family members and health-care professionals understand what a dying person is going through; this can enable them to be patient and empathetic. It also allows a caregiver to aid, rather than hinder, the dying person to achieve the kind of death wanted. "Some want to go ou fighting," she says, "and they should. We should not try to impose our will on then If you listen to the patient, he or she will tell you how he or she wants to die."

Most people in our society tend to ignore or avoid thoughts of death, but death is a fact of life. A terminal illness in the family usually puts greater stress on everyone than a tempory illness does. In a case like this, "home care" means relieving that stress whenever possible. Understanding the stages the dying person goes throug will help the patient and the caregivers to accept the inevitable. Family members must also go through a process of acceptance. All this takes time, and is not easy; however, a deep, compassionate, and loving relationship can provide a solid suppo for everyone involved in this type of situation.

4. It's possible that you have experienced the death of a family member or a friend. If so, take a few minutes (if it's not too painful) and describe your own feelings at the time.

Compare your answer with the one in the Appendix, Section 1: Activity 2.

It helps if the people who have terminal illnesses are able to talk freely about their pains and fears. As a caregiver, a friend, or a family member, you should try to let the ill person know that you care, empathize, and understand. You can lessen the dying person's fears if you genuinely love the person and care about what that person is going through.

5. To complete this activity, examine each of the following statements and decide if you agree or disagree. If you disagree with a statement, rewrite it to make it acceptable.

   a. A caregiver should concentrate on a patient's physical ailments; if they're looked after, the patient's emotional recovery is assured.

   b. Only one family member can be a caregiver; otherwise, the situation becomes confusing for the patient.

   c. Diversions can be provided by activities that aren't too difficult and will help the patient feel good.

   d. Rehabilitation can begin the moment the ill or injured person has recovered.

   e. It isn't necessarily unhealthy for terminally ill people to feel angry and resentful about their condition.

Compare your answers with those in the Appendix, Section 1: Activity 2.

In this activity, you have been introduced, on a general level, to a few issues facing the primary caregiver in a home-care situation. In the next activity, you'll begin to look at these challenges in more depth.

ACTIVITY 3

The Role of the Caregiver

Imagine that a member of your family requires long-term care and has been assessed as a home-care candidate. You and the other members of your family now have many decisions to make. Determining how much care the patient will need and how you're going to provide it requires a close, matter-of-fact assessment of the situation and professional advice. In this activity, you'll look at some of the considerations for you and your family in making decisions of this type.

Considering the Role

Before accepting the role of caregiver, you'll need to evaluate your attitude toward the whole business of giving care. Remember, as caregiver, you'll be making decisions, scheduling appointments, anticipating the patient's needs, and planning for emergencies—as well as looking after the day-to-day needs of the care-receiver. In evaluating your attitude, you should seriously ask yourself questions like the following:

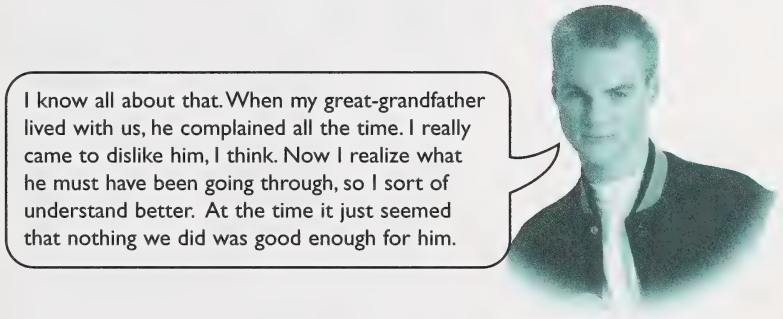
- Do you fully understand the responsibility you're undertaking and its implications for your life?
- Do you really want this responsibility, or are you accepting it only because you feel obligated?
- Will you be able to shoulder the responsibility and still manage to have the time and energy to lead a life of your own?
- Will you get the support you'll require from other family members?
- Are you prepared to spend time planning and consulting with health-care professionals?

Before assuming the responsibility of home care, be sure to examine the quality of life that you and your family now enjoy. You have your own routines, social lives, jobs, financial obligations, and health issues; it's important to know just what adjustments you'll have to make in areas such as these.

1. Imagine that you have to help out at least three hours a day in caring for a family member at home. Suggest **three** aspects of your present daily schedule that may have to be adjusted.

Compare your answer with the one in the Appendix, Section 1: Activity 3.

Before becoming a caregiver in the home, you should seriously consider your attitude toward the care-receiver. Remember, patients may not be well, but they will still have definite ideas about how they wish to be treated. Are you sure you will be able to respect the wishes of the care-receiver? What adjustments will have to be made to give that person privacy, quiet times in which to rest, and stimulation? The care-receiver may experience some problems coping with the illness or injury, and may cause some complaints or discontentment with your efforts. Can you deal with this type of emotional impact?



2. How would you cope with a care-receiver who constantly criticized or complained about the care you were giving?

Compare your answers with those in the Appendix, Section 1: Activity 3.

Prospective caregivers should also examine their expectations of others. What responsibilities do they expect other members of the family to undertake? Do those members have the same expectations? And just how closely do the caregivers expect health-care professionals to work with them?

3. Imagine that you undertook to care for a family member in your home only to discover that other members of your family—and professionals you hoped to work with—failed to meet your expectations of their roles. What would your reaction likely be?

Compare your answer with the one in the Appendix, Section 1: Activity 3.

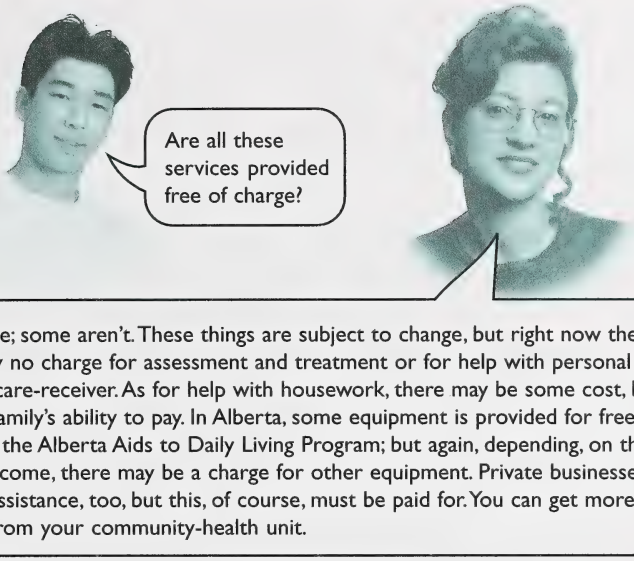
As a home-care provider, you should seek information and advice. The more information you have, the better you'll be able to cope. The doctors or the institution who attended the patient previously may provide referrals to agencies that will supply helpful information and materials. Also, the regular visiting of nurses and aides to the home—to monitor the patient's progress and provide professional care and advice—may be a major aspect.

Your local community-health may provide a nurse from Community Care to evaluate your home for necessary changes to make the patient more secure and comfortable. This unit may also be able to supply some of the equipment you'll need. The Canadian Red Cross and St. John Ambulance may be able to provide additonal information and materials. Try to find other available services.

4. Look in the phone book for your area and make a list of agencies that might provide information and assistance to a home-care provider. Check those pages near the front of the directory with colour-bordered pages.

Compare your answer with the one in the Appendix, Section 1: Activity 3.

Frequently, a family providing home care discovers that they need help with more than information, materials, medical services, and monitoring: they may also need support services. This may be assistance with personal care for the care-receiver or help with household tasks–cleaning, cooking, and so on. Often care-receivers are well enough to stay in their own homes but not able to look after themselves completely. Sometimes family members feel uncomfortable helping the patient with basic physical hygiene such as bathing and toileting; often the patient, too, would prefer that this not be done by family members. In such cases, home-care aides are normally available to help out.



Needs like these are also generally met by local community-health units. Care-receivers may require assistance in developing skills to resume independent living or may need help to assist with therapy activities to regain strength.

5. a. If you were the primary caregiver for a family member, with what tasks would you appreciate outside assistance? Think of duties other members of your family would, and likely would not, be able or willing to do.

   b. Contact your local community-health unit and ask for literature on the home-care services provided. If you can, prepare several questions in advance and, if you're able to speak to the health-care professional in charge of home care, see what you can learn about the way the program works. Ask about fees for services and costs or charges for purhcase or rental of equipment.

Compare your answers with those in the Appendix, Section 1: Activity 3.

All caregivers must reassess the situation at regular intervals in order to determine whether the responsibilities are taking too great a toll. Perhaps the physical, emotional, and social costs are too high. If the pressures of caregiver stress are too great and the sacrifices are too costly, it will be necessary to look for solutions or alternative arrangements.

It should be noted that if you must place your loved one in a long-term care facility such as a nursing home, the care received may not be as thorough nor as intimate as the care you were able to give. For this reason, you should make arrangements to visit your loved one often, and at varying times of the day. This will also provide you with a check or assurance that the care being given is the best possible.

Following is a set of questions designed to assess the situation of someone who is already providing care to a relative within the home; they also might be useful for anyone who is considering taking this step. After that comes a worksheet used by health-care professionals to evaluate a home-care situation. Read them both, and then respond to the statement that follows.

REVIEWING THE SITUATION

Date of review _____

1. Were you given adequate description and instruction regarding what you would be doing? Yes ____ No ____
2. Were you given enough background information about your relative? Yes ____ No ____
3. Have you met all the professionals and community workers relevant to your relative's situation? Yes ____ No ____
4. Do you report your relative's condition to anyone regularly? Yes ____ No ____
5. Have the professionals/community workers maintained regular contact with you? Yes ____ No ____
6. Do you feel your relative is benefitting from your involvement? Yes ____ No ____
7. Do the professionals/community workers give you detailed instructions about new tasks they would like you to do for your relative? Yes ____ No ____
8. Are you included during evaluations and assessments of your relative? Yes ____ No ____
9. Do you feel you have received adequate training for what you are doing for your relative? Yes ____ No ____
10. Do you feel the professionals/community workers appreciate your contribution? Yes ____ No ____
11. Do you feel your relative appreciates your contribution? Yes ____ No ____
12. How long have you been the main family care-giver?

    _____

13. What are some of the reasons you became the care-giver?

    _____

14. What satisfaction(s) have you had as care-giver?

15. What frustrations have you encountered?

16. What things do you feel need improvement?

17. Do you know where to get additional help in your community?

18. Note any other thoughts.

[1] Jill Watt, *A Care-Giver's Guide*, Second Edition (Vancouver: Self-Counsel Press, 1994), 61–62. Reprinted by permission of the author.

THE PROFESSIONAL/COMMUNITY WORKER'S VIEW

Date of review _____

Name of patient/client _____

Name of family care-giver _____

1. Description of the family care-giver's contribution and activities with the patient/client.

   _____

   _____

2. For what period of time has the family care-giver agreed to undertake this responsibility? _____ weeks _____ months

3. Has the family care-giver received adequate instruction and the information necessary for activities with the patient/client? Yes _____ No _____

4. How much time does the family care-giver spend with the patient/client?

   _____

5. When did the family care-giver last get in touch with you (by phone or in person)?

   _____

6. How often do you see the family care-giver? _____

7. What things could the family care-giver do that would help you (with the patient/client) that isn't already being done?

   _____

   _____

8. Is the family care-giver maintaining his or her own health (physical and mental)? Yes _____ No _____

9. Are there any ways you could help the family care-giver? What are some of the ways?

   _____

   _____

Name of professional/community worker _____

[1] Jill Watt, *A Care-Giver's Guide*, Second Edition (Vancouver: Self-Counsel Press, 1994), 63. Reprinted by permission of the author.

6. Basing your answer on these questionnaires, identify **three** important concerns that anyone involved in home care should think about.

Compare your answer with the one in the Appendix, Section 1: Activity 3.

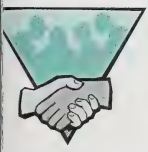
The Rights and Responsibilities of Caregivers and Care-Receivers

Caregivers and care-receivers do not have special rights and responsibilities guaranteed by law. Nevertheless, there are certain understood principles for conducting their affairs. Both care providers and the people they're looking after can expect to have certain rights; conversely, certain responsibilities are expected of them. The charts that follow outline some of the rights and responsibilities most people agree upon.

RIGHTS AND RESPONSIBILITIES OF CAREGIVERS

Rights	Responsibilities
• the right to help and advice from health-care professionals	• the responsibility of knowing the names of doctors and other professionals working on the case
• the right to co-operation from the care-receiver	• the responsibility of knowing the care-receiver's health history and any medications taken
• the right to respectful treatment by health-care professionals working on the case	• the responsibility of administering medications as prescribed
• the right to be involved in decisions concerning the health of the care-receiver	• the responsibility of reporting any changes you see in the care-receiver's health
• the right to be kept fully informed about changes to the health of the care-receiver	• the responsibility of being honest and direct about anything relating to the care of the care-receiver
• the right to be treated honestly and directly	• the responsibility of helping the care-receiver keep scheduled appointments with health-care professionals

Teamwork



7. Can you think of any other rights and responsibilities that you believe ought to be included in this chart? See if you can come up with **one or two** for each column. If you can, brainstorm ideas with a friend or classmate.

Compare your answer with the one in the Appendix, Section 1: Activity 3.

RIGHTS AND RESPONSIBILITIES OF CARE-RECEIVERS

Rights	Responsibilities
• the right to considerate and respectful health care regardless of lifestyle, income, culture, educational background, or diagnosis • the right to the services of competent health-care professionals • the right to be involved in decisions regarding your own health care • the right to seek consultation in health care and to change physicians if it seems necessary • the right to be made aware of health-care services available to you • the right to respect and privacy • the right to a healthy and safe environment	• the responsibility of co-operating with your caregiver and treating him or her with respect • the responsibility of co-operating with health-care professionals and, as much as possible, following the instructions they give you • the responsibility of informing your caregiver and health-care professionals of any symptoms or changes you notice • the responsibility of doing everything reasonably possible to recover

8. Now see if you can add an idea or two to each column of this chart.

Compare your answer with the one in the Appendix, Section 1: Activity 3.

The Primary Caregiver

As you can see, there's a good deal to consider in making the decision to become a care provider in the home. As noted, normally one member of the family will have to take the role of primary caregiver. This person will be responsible for organizing the care routines, remembering that the responsibility of home care lasts 24 hours every day.

In most families, the decision as to who will assume this responsibility isn't hard to make. It's generally the person primarily in charge of household routines and providing care for others. Traditionally, this has often been the adult female in the home, and this is still usually the case; however, it's not as self-evident as it once was. Today, when both parents often work outside the home, the principal caregiver may be the adult male or an older child.

Though the decision who will be primary caregiver may be fairly self-evident, it should still be considered seriously. The following factors should be taken into consideration:

- **available time**–Who will be available to provide the home care? Will someone have to give up a job or quit an activity in order to provide the care? Could the family finances sustain a loss of this sort?

- **management skills**–Who can arrange and organize the ill or dependent person's care as well as the home life for other family members?

- **planning for emergencies**–Who can think ahead and be prepared if an emergency occurs?

- **communication skills**–Who will be most comfortable and effective talking with doctors, the family, friends, and the care-receiver?

- **physical and emotional health**–Who has the energy, strength, and conditioning to look after the physical demands of home care? Who has the personality and attitude needed for the demands home care makes?

- **comfort levels**–Who can handle caring for someone who is ill? Who won't faint at the sight of blood or vomit? Who will be able to bathe the patient and help him or her in the bathroom? Who can handle the waiting involved with doctors' appointments and medical tests? Even though you may feel you are unable to do these things, you may surprisingly find the capability when presented with the situation.

- **priorities**–Who is able and willing to give up time currently spent on other activities? What will these activities be now? How can arrangements be made to accommodate this person's own interests and allow time for the rest of the family?

9. If your family were to assume the responsibility of home care, who do you think would take on the role of primary caregiver? Give reasons for your answer.

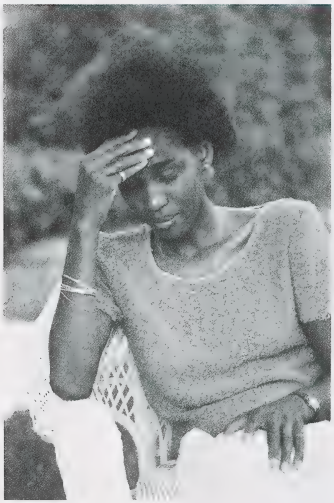
Compare your answer with the one in the Appendix, Section 1: Activity 3.

As you've seen in this activity it's almost always necessary for one member of a household to take on the role of primary caregiver. This responsibility, as you can imagine, can become a burdensome one: a person assuming this role can easily become exhausted and ultimately so "burned out" that providing adequate care becomes impossible. For this reason, caregivers must look after themselves as we as their patients. You will examine this in the next activity.

ACTIVITY 4

Care for the Caregiver

The Stresses and Strains of Being a Caregiver



JIM WHITMER PHOTOGRAPHY

convalescent: *a person who is healing or recovering from an injury or illness*

As a caregiver, you must remember to be sure to care for yourself—as well as for the patient. At first, this may seem rather selfish, but think of it this way: if a caregiver becomes sick or exhausted who will look after the care-receiver? If you, a caregiver, become exhausted, physically or emotionally, you're likely to become irritable and unable to function properly. This could interfere with your sleep, your appetite, and your interest in life. When you feel like this, what are the chances that you'll be able to provide the kind of care and the positive, healing environment that a **convalescent** needs?

What this means is that if you're a caregiver and you feel you're working too hard, you must arrange a day off. You must remember to find time to look after your own interests. You may need a place within your home or an activity that will relax you. You may even need to arrange for help for an extended time so you can have a vacation. Caregivers can't sacrifice their own lives for their patients; if they try, it's almost guaranteed that no one will end up better off in the long run.

Alzheimer's disease: *a degenerative disease of the brain and nervous system that causes dementia (a deterioration of the mental processes)*

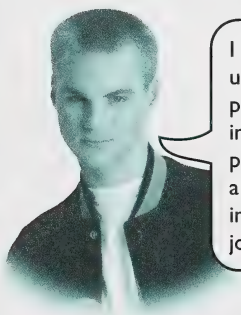
1. Mrs. Kabaroff is primary caregiver for her husband, who's suffering from **Alzheimer's disease**. Because her husband tends to wander off if left unattended, Mrs. Kabaroff feels she can't leave him alone for more than a few minutes at a time. Her children (all adults) feel that their mother ought to place Mr. Kabaroff in a home, but Mrs. Kabaroff swears that she married her husband "for better or for worse" and she has no intention of "abandoning" him and entrusting his care to "strangers." Besides, Mr. Kabaroff becomes extremely agitated in unfamiliar places.

   Mrs. Kabaroff is clearly overworked and is becoming exhausted. If she asked you for advice, what would you tell her? Explain your thoughts fully.

Compare your answer with the one in the Appendix, Section 1: Activity 4.

Innovation

The stress of being a caregiver isn't only physical. It is emotional as well and especially true if you're watching someone you love decline in health. If you, as a caregiver overextend yourself to the point of physical and mental exhaustion you can end up needing care yourself.



I know that's true of health-care professionals. My uncle is a nurse, and he says that if you want to provide the best care you can for someone sick or injured, you must try not to take things too personally. I suppose doing that is a lot harder if it's a family member situation; but he says it's very important to take time for yourself away from the job of caregiving.

For this reason, one thing that's very important for a caregiver to learn is time management. It's also important to learn to ask for help. If the care-receiver is taking an increasing amount of your time, you, as caregiver, have to consider alternate arrangements for at least one evening out now and then. You need time to visit friends, go shopping, or see a show. This can require more planning and arranging than it once did, and for that reason some caregivers simply give up trying. However, allowing yourself "to get away from it all" with caring friends will re-energize you emotionally, and possibly physically as well.

It may give you what you need—to look at the situation from a new perspective.

Home-care workers recognize that primary caregivers, especially those in situations where a great deal of time and energy must be devoted to their care-giving role, must take regular breaks. But in these situations, somebody mus be there to look after the care-receiver. People who fill in for caregivers in this wa are said to provide **respite care**—something that's recognized as vital for caregivers. Perhaps a *respite caregiver* can come to the home once a week to relieve and give the primary caregiver a chance to get out alone—or with friends– for a while, away from those weighty responsibilities.

respite care: *care provided for a primary caregiver who needs a break from the stresses of providing home care*

Respite care may be provided by a local community-health unit or, for a price, by a private business or agency. Of course, some primary caregivers may be fortunate enough to have a family member or friend who can provide respite care.

People who care for family members in their home often develop their own methods of looking after themselves. The following is a list of general recommendations and techniques for the beginning caregiver to make the job easier.

- Use calendars to mark down medical appointments as well as outings for yourself. Schedule your days off.
- Use lists for organizing your day. Lists are a visual reminder of what you need to do or plan to do within the day. They can help you show others what you do when they come in to lend a hand.
- Involve your care-receiver in scheduling daily activities. Encourage the person to suggest suitable activities for that day. You can schedule in-home visits for other family members.
- Write telephone messages down and place them in one location. Other family members can check this location for their messages. If the message is for the care-receiver, convey it personally, but keep a written copy of it.
- Assess where your time goes. Every couple of months, review and evaluate your situation. Do you find that you're spending more time caring for the care-receiver than you did at first? Do you now have to assist the care-receiver with eating or other functions that you didn't have to do weeks ago. Decide if you have a healthy balance between personal and care-giving activities.

- Give others the chance to help. List tasks other people can help with or ask what they would feel comfortable doing. Don't get the idea that only you can do the job.

- Take care of your own medical needs. Don't postpone annual medical checkups or visits to the dentist. You need to care for your physical and mental health.

- Make decisions. Often members of the family will have differing ideas on what should be done and who should do it, and often the result is that no decision is arrived at. Set aside a certain time when you and other members of the family, and the care-receiver, can discuss issues and reach an agreement.

- Ask experts for advice. Talk to your physician or the local community care unit about things you're concerned about.

- Start your own collection of resource materials. Take advantage of free printed materials available at your community hospital or health unit.

- Contact a mutual support group. There are associations that help care-givers who are coping with loved ones who have a serious illness or medical condition. These days it is possible to find support groups like this for almost any illness. If there isn't one right in your community, the Internet or your local health centre will likely be able to provide you with a support group that spans the globe. It's amazing how helpful it is to talk with people experiencing the same problems.

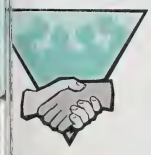
- If you or the person you're caring for belongs to a church or other place of worship, contact the appropriate religious leader. The **parish nurse** or members of the parish may be able to help with meals, visiting, encouragement, and prayers.

- If providing home care has you taking on too much responsibility—cancelling your regular activities, sleeping less, following the doctor's orders for the care-receiver, and spending all of your time giving the care-receiver a good quality of life—then you need to change the situation.

- Be honest with yourself, the care-receiver, and other members in the family. If you discover that you simply don't have the physical or mental energy to provide home care, don't feel guilty about it. It can be a long, demanding job. To end or reduce your care-giving responsibilities, you'll need to talk with the care-receiver, notify the health professionals involved, and talk to other family members. Ultimately, everyone will be better off if you deal with the situation honestly right up front.

rish nurse: *a gistered nurse o is a member the ministry m who helps embers of the ngregation to come more are of their alth and move ward a fuller se of wholeness*

Teamwork



2. Can you think of **one** or **two** more good suggestions to add to this list? If you can, brainstorm ideas with a classmate or friend.

Compare your answer with the one in the Appendix, Section 1: Activity 4.

Common Problems Faced by Caregivers

If caregivers look after themselves, the chances that they'll be able to look after their care-receivers effectively are greatly increased. Still, a caregiver has to be prepared for what's to come. It's important to note that even in the best home-care situations, there will be stresses and strains. Primary caregivers who understand this and can anticipate some of the difficulties they're bound to face will be in a better position to overcome those difficulties.

JIM WHITMER PHOTOGRAPHY

But just what problem areas should a caregiver anticipate? Following is a list of some common problems that caregivers mention when asked this question. Note that the discussion is set up as though *you* are the primary caregiver.

dementia: *an abnormal deterioration of the mental processes*

- The care-receiver may begin to distrust you. This occurs most often with elderly patients, especially those suffering from some form of **dementia.** It can be very hurtful, especially when the patient is someone that you love an for whom you feel you're doing so much; so, it's important to recognize that this is a common problem in a home-care situation. It doesn't reflect on your ability to provide care. When this situation does arise, you should simply try to accept the fact and, if possible, get another person whom the care-receive does trust to do the tasks the care-receiver is concerned about. These could include things like looking after dressings, helping the patient walk, pushing the wheel chair, or taking care of financial arrangements or legal matters.

- You aren't able to detect changes in the care-receiver's condition until it becomes a crisis. If the change is gradual, you may not become aware of the situation until someone who doesn't see the care-receiver daily notices it. Th is one area where recording your care-receiver's vital signs may help. Recording your observations daily may also help you notice changes more readily.

- You may not receive any credit or gratitude for the job you're doing. This is something you may just have to accept. The fact is that providing care can at times seem to be a thankless job, especially when the care-receiver isn't improving and may actually be declining. If you're feeling so hurt by the situation that it's affecting your life and the job you're doing, you should try to find someone to confide in and who can look at the situation objectively. You must also learn to provide yourself with your own rewards; don't expect them from others.

- You may begin to feel that you're constantly waiting. You could be waiting for doctor's appointments, tests, treatments, or results. You may also be waiting for information, phone calls, and the next emergency. If you're bothered by waiting, you must find a way to make the time productive or learn to use it to relax. This isn't always easy, expecially if you're not a patient person. But waiting often just seems to "go with the territory" when it comes to home care.

3. Imagine that you're a caregiver who must spend a good deal of time simply waiting. Suggest several things you might do to use the time productively.

Compare your answer with the one in the Appendix, Section 1: Activity 4.

- Your care-receiver may experience the need to talk continuously. This may become a constant nervous habit. If so, you may need to arrange for more visitors or to be spelled off more frequently by family members or other respite caregivers. It's important to take enough breaks yourself to be able to think clearly and re-energize.

- You may discover that your care-receiver is becoming totally dependent on you and even perhaps, starting to worry about strangers coming into the house. If so, you'll have to spend a good deal of time reassuring the patient that there's nothing to worry about. It may be a good idea to try to increase the number of people paying visits in order to keep the care-receiver used to seeing different faces. However, before increasing the number of visitations, you must consider the ability of the care-receiver to handle more visitors. Perhaps the care-receiver would become too tired or stressed.

- You may experience a sense of grief and sorrow as you watch your care-receiver decline. This is very normal in situations where recovery is unlikely and you're simply working at comforting the patient as the illness progresses. Watching people you love lose their abilities to do things, and possibly even losing their personalities and their ability to recognize you and remember things you've shared, can be extremely upsetting. The sense of loss can be similar to that experienced when a person dies–in some ways even worse, since there's no sense of closure or finality.

That reminds me of when Mum was looking after her own mother. Her mother's memory got worse and worse, and finally the day arrived when she didn't even recognize Mum—her own daughter! Boy, I never saw my mother so hurt, after all she'd done and sacrificed for Grandma. That's just what happens sometimes and you have to accept it.

If you find yourself, as a caregiver, experiencing feelings like these, you cou try the following:

- Admit to yourself that it's normal and natural to have these feelings.
- Keep a sense of humor to make the situation less hurtful.
- Find something to do that lets you work your feelings out in a positive manner.
- Consider future possiblities. Remind yourself that life goes on and that someday you'll be able to put what's happening now behind you.
- Take the time and effort needed to discuss things like funeral arrangements, if your care-receiver is dying and is concerned. Make sure that you're aware of the care-receiver's final wishes and give assurances that you understand them and will see that they're carried out.
- Seek counselling, especially from support groups of people experiencing the same things you are.

- If you find yourself losing your enthusiasm for living, don't just ignore it. Be concerned and seek help. Following are a few indicators that this may be taking place:
  - You find yourself walking and talking more slowly than you used to.
  - You seem to read, think, and respond to things more slowly.
  - You notice that you're frequently avoiding or postponing doing things and decreasing your range of activities.
  - You find that you have little interest in things that are new or in friends' conversations and activities.
  - You discover that either consciously or unconsciously you're mimicking th care-receiver's actions.

- You and your care-receiver may need to deal with feelings of isolation and loneliness. If so, you should encourage more visitors for yourself and the patient. You should also make arrangements to get involved in activities that get you out of the house and meeting people.

4. Suggest a reason why people in home-care situations frequently find themselves faced with the problem of isolation and loneliness.

Compare your answer with the one in the Appendix, Section 1: Activity 4.

- You may have to face the fact that you simply can't provide the help your care-receiver needs. Here are a few things that can indicate the need to turn this responsibility over to another caregiver with more time, experience, and resources, or to a medical staff:
  - Your care-receiver won't co-operate with you but will with others.
  - Your care-receiver begins to lie and tell people that you don't love, or are trying to harm, him or her.
  - You're constantly being criticized by your care-receiver no matter what you do.
  - You find yourself becoming constantly angry and irritable and find yourself complaining frequently.
  - Your care-receiver develops certain physical problems. These include sores on the buttocks and pressure areas such as the back, shoulders, feet, and ankles. Also the care-receiver may develop a tendency to bruise easily and to flinch when touched.

5. Have you ever experienced caring for a family member who is unwell or injured? Perhaps it was the time your mother was at home with her broken leg, when your father was recovering from pneumonia, or when your little sister had tonsilitis. If you have looked after someone confined to the home for a period of days or longer, what were some of the problems that you experienced as a care provider? Think of the behaviour of your "patients," the demands they placed on you, and your own feelings about looking after them.

Before leaving the issue of stresses faced by caregivers, mention should be made of the problems that can arise at the conclusion of the care-giving period. Many primary caregivers find that over time their whole lives have come to revolve around their care-receivers, and their sense of self-worth has become completely dependent on the feeling they've had of being constantly needed. When the experience comes to an end, caregivers can become depressed, lost, and dispirited—and often they have problems re-structuring their lives.

I have an idea. I think if I were in that situation I might consider helping other caregivers. I mean, think of all the experience I'd have and all the advice I could give. Maybe I could volunteer to provide respite care or at least provide moral support for others going through what I'd experienced.

That's an excellent idea. I'm sure anyone in this situation would appreciate your help and support.

Compare your answer with the one in the Appendix, Section 1: Activity 4.

In this activity, you've looked at how important it is for people undertaking the responsibility of home care to look after themselves. Professionals working in home care must be very aware of this issue too and be alert for signs that a caregiver is under too much stress and in need of more support. Providing home care is an extremely taxing undertaking; a task no one should get into without a great deal of consideration and a solid support network.

FOLLOW-UP ACTIVITIES

If you had difficulties understanding the concepts in the activities, it's recommended that you do the Extra Help. If you have a clear understanding of the concepts, it's recommended that you do the Enrichment.

Extra Help

1. *Home care* is a term used when persons who are no longer able to care for themselves are permitted to stay at home, under the care of other persons designated as the primary caregivers. Test your knowledge of some of the basic principles of home care in Alberta by indicating whether each of the following statements is true or false. Correct each false statement.

   a. Only people with acute conditions qualify for home care.

   b. Home care is sometimes appropriate for people with incurable diseases and who are approaching death.

   c. Children and teenagers are never considered candidates for home care.

   d. All the costs of home care are borne by care-receivers and their families.

   e. People opting for home care are supervised and aided by trained health professionals.

   f. People with short-term needs, such as those recovering from an injury, may qualify for home care.

   g. Another term for home care is *respite care.*

   h. Diversion is a more appropriate focus of home care than is rehabilitation for a palliative-care patient.

2. Frequently, caregivers in home-care situations must deal with a family memb who is dying. Accepting death is a very difficult thing, and caregivers should be prepared for the stages a terminally-ill patient is likely to go through. Without looking back, if possible, list the **five** stages common to anyone facin death, according to Dr. Elisabeth Kübler-Ross.

3. Identify at least **three** major concerns health-care professionals have when setting up and monitoring a home-care situation.

4. Having an ill person at home requires changes in normal household routines. Each member of the family will be affected, but by accepting the changes and learning how to cope, everyone can play a role in helping maintain a comfortable quality of life in the home. A few basic guidelines for coping with home-care situation are as follows:

   - To be able to provide effective home care, caregivers must maintain goo mental and physical health.
   - A family providing home care must maintain good communication with the care-receiver, with health-care professionals involved in the case, and amongst themselves.
   - It's necessary to understand the emotional, as well as the physical, impac of the illness on the care-receiver.
   - Family members should learn how to carry out a few simple procedures involved in caring for the care-receiver.

   Bearing these points in mind, identify the basic responsiblities of a primary caregiver.

Compare your answers with those in the Appendix, Section 1: Extra Help.

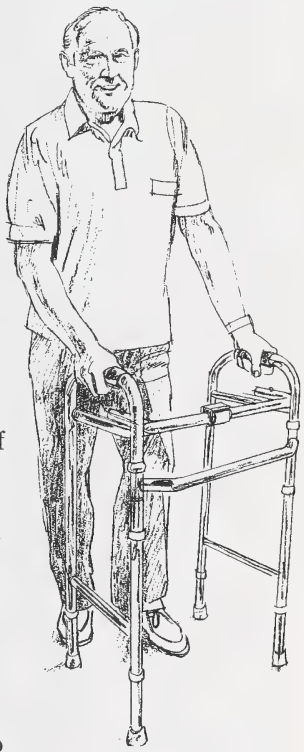
Do **one or both** of the following.

1. If you have access to the Internet, do some web surfing and see what you can learn about topics related to home care. There are many sites that you might discover by using keywords such as *caregiver*, *hospice*, or *longterm care*, but an excellent Canadian site that might be a good place to start is the Caregiver Network at the following address:

   http://www.caregiver.on.ca/

   If you do access this website, move around in it and see what you can learn. A good way to start would be to click on the *Caregiver Info* button.

2. *Eldercare*—caring for the elderly—is becoming an increasingly difficult problem in our society. With governments trying to curb health-care spending while our population is aging, the problem promises to get worse over the next few decades. The largest age-group in our society has for the last forty or fifty years been the so-called *baby-boomers*—those people born in the "baby boom" that followed World War II. Baby boomers are now middle aged, and it won't be long before they become elderly. When this happens, no one knows how our current system will cope with all those aging Canadians in need of care and medical services. Meanwhile, those same baby boomers are frequently forced to look after their own parents while taking care of the demands of their jobs and families at the same time.

   Home care is one partial solution to this problem, but with most families now requiring two wage-earners, there doesn't seem to be enough time to care for the children, let alone elderly relatives. Yet something must be done.

   A number of extracts from a cover-story article of a January, 2000 issue of *Maclean's* magazine follows. To become more aware of the challenges involved in this issue of eldercare and the role home care can play in it, read the article; then answer the questions that follow it.

All in the Family

In retrospect, Surrey, B.C., systems analyst Janet Ollhoff can hardly believe she managed it. In November, 1998, her life was thrown into turmoil when her father, Hans, suffered a debilitating stroke. While he struggled for survival in a hospital intensive care unit, the 38-year-old Ollhoff moved her mother, Irmgard, into her own home. For a decade, her father had taken care of Irmgard after she suffered her own massive stroke. Ollhoff's days became exhausting and emotionally draining. She had to do everything for her mother, from cutting food into small bits and changing her diapers to monitoring her diabetes and heart condition. In the evenings, while her husband, Al, looked after her mother, Ollhoff visited her father, lifting him onto the toilet or feeding him when nursing help was unavailable. Juggling their needs and her own job took its toll. "I felt completely isolated," Ollhoff recalls. "No one could understand what I was going through."

Such stories are becoming alarmingly common. Tens of thousands of Canadian baby boomers are confronting the challenge of taking care of their parents, often when they are heavily weighed down by the demands of careers and family life. Every family copes in its own way but the issues each faces are remarkably similar. What does a diagnosis of chronic illness—stroke, Parkinson's disease, osteoporosis—really mean? Will it be possible to care for an elderly spouse or relative at home, or is an institution the only answer? If so, will there be enough money to pay for quality care that can easily cost thousands of dollars *per month*?

Then there is the guilt. In Ollhoff's case, it came last fall, after she placed her parents, both 70, in a nursing home in nearby Cloverdale. Although she vistits them every evening—the nursing home is about 20 minutes from her home in Surrey—she still wrestles with the emotional fallout of deciding to move them to an institution. "I cry all the time," she says. "There is major guilt. Maybe if I'd spent more time with my mom, my dad wouldn't have gotten sick."

The dilemmas of caring for the elderly are not new, but there is no doubt that finding solutions is more urgent than ever before. By 2021, Health Canada estimates, there will be 6.9 million Canadians over the age of 65, almost double the current number. An alarming proportion will have Alzheimer's disease, an increasingly common form of dementia that is already straining services for the elderly. "I believe there will be a crisis if we don't plan properly," says Marlene McClellan, associate director of the Nova Scotia Centre on Aging at Mount Saint Vincent University in Halifax. "It is, however, one that can be fully averted. This is the most predictable demographic change we've ever had."

To tackle that problem, governments will have to build far more facilities and provide better home-care services than are available right now. In fact, families who have struggled to find affordable care for their relatives say the crisis is already here. On average, only seven per cent of seniors require long-term institutional care, yet many people with relatives in nursing homes cite shocking levels of neglect and incompetent care. As well, conditions inside some homes can be grim—wards rank with the smell of urine, residents locked in their rooms to prevent them from wandering. When family members complain, their concerns are often dismissed by overworked staff who are irritable, tired and angry.

Adding to families' concerns is the bewildering quilt of so-called government standards across the country. In Ontario, "nursing homes" are subsidized and regulated while "retirement homes" are not. There are also wide disparities among the provinces on home care. British Columbia imposes no limit on the number of hours of home care—service provided to seniors in their homes by health-care professionals. In Prince Edward Island, only 28 hours a week of such care is paid for by the government. Karen Parent and Malcolm Anderson, authors of a 1999 report on home care in Canada, argue that there is no coherent strategy, nor sufficient money and manpower, to provide these services. "That's fine for people who can afford to buy private care, or for those with low incomes who qualify for subsidies," says Anderson, the director of research at the Queen's Health Policy Research Unit in Kingston, Ont. "But there is a middle band of people who become impoverished by having to provide for themselves. The growing trend is that more and more responsibility is being placed upon families to provide the care that was once publicly funded."

There is mounting pressure to improve what professionals call the eldercare system. Statistics Canada reports that 90 per cent of such care in Canada is provided by family members, and most of those people are middle-aged baby boomers, who are accustomed to agitating for change. David Globerman, for one, was so incensed by the care his father received at an Ottawa hospital in 1996 that he started the Running to Daylight Foundation, a Toronto-based organization devoted to improving institutional eldercare. Globerman, 46, says he believes his 85-year-old father was given low priority by medical staff because of his age: he died within weeks of entering hospital, largely, Globerman believes, because doctors treated him for pneumonia when in fact he had suffered a stroke. "Clearly, there is a bias in the health-care system against the elderly," says Globerman, who is a financial consultant to the Ontario ministry of health in Toronto. "As a society, we don't value them. So when there is a lack of resources, they fall to the bottom of the barrel."

Distance, money, a full-time job: those realities prevent many adult children from taking care of their elderly relatives, even if they had the emotional and physical reserves to do so. Perhaps because their options are so limited, they often convince themselves that good long-term care will be available if and when it is needed. But that, many experts say, is a dangerous assumption. Ernie Lightman, a professor of economics in the faculty of social work at the Univeristy of Toronto, has been studying seniors' care for two decades and says that almost all the provinces have tried to limit their inventories of long-term and chronic-care beds, which can range from $150 to $500 a day to maintain. That has resulted in lengthening waiting lists and declining standards: in Ontario, about 18,000 people are lined up for a place in a government subsidized nursing home, forcing many into unsubsidized, unregulated retirement homes where the quality of care ranges from excellent—with huge fees—to deplorable.

Indeed, Lightman says, backing away from regulation is seen by some governments as an ideal way to stay clear of the whole messy business. "If the government has no responsibility, when someone dies in one of these homes, the minister doesn't have to answer for it in question period," he says. "It cuts costs." Lightman, who believes that home care is the only option for the future because it costs far less and is a more humane way of caring for the elderly, says he is deeply pessimistic about improving the general quality of long-term care institutions. The vast majority, he says, are and will remain "warehouses for death."

In fact, keeping parents at home is the choice made by the vast majority of Canadians. According to a new report by Statistics Canada, about 2.1 million Canadians are caring for senior relatives, either in their own homes or in the patients' homes. About 60 per cent of those caregivers are women, most of them have other jobs, and a quarter were also looking after children under the age of 15. And while the StatsCan survey found that most people felt good about caring for elderly relatives, it also documented their costs in lost career opportunities and personal time.

Sheila Porter, 61, can attest to both the rewards and the trials of caregiving. In 1992, her mother suffered a stroke, and Sheila and her husband, Art, uprooted themselves from their home and careers in Calgary and moved back to the tiny house in Sackville, outside Halifax, where she grew up. Porter, a new-products demonstrator, was determined that her mother would not be forced to leave the neighbourhood where she has lived for 50 years. Seven years later, Porter is still struggling with her new life. Pearl Worthen, now 85, is paralyzed on one side, has impaired speech and does not understand verbal directions. A refined woman who still enjoys dressing up and wearing makeup, she now requires help with daily basics like bathing and brushing her teeth.

Porter has no regrets, but she wishes she had been more prepared for her role as a caregiver. There are times when she feels that her acts of caring have become a job and she craves more time for herself: although government-paid home-care workers help out three times a week, the house is so tiny that Porter must leave when they are there. The best solution, she says, would be a long-term care facility in Sackville, so that she could visit her mother daily, but there isn't one. "After my generation, I'm afraid for old people," Porter says. "They better have more places for the elderly, or they'll be out on the street."

Still, quality nursing homes cannot look after the vast majority of seniors. The better solution for them, according to a 1998 recommendation by the National Forum on Health and supported by many leading gerontologists, would be a national system of home care. Embracing everything from weekly housekeeping to daily visits from a registered nurse, home care allows elderly people to remain in familiar surroundings until the last stages of physical decline. It is far less expensive than institutional care—estimates range from $50 to $200 a day—and is more emotionally satisfying for both the elderly and their families if there is enough support from visiting professionals. "In the past few decades, we have found that things other than hospitals, drugs and tests are crucial for good health," says Neena Chappell, director of the Centre on Aging at the University of Victoria. "good social supports, more exercise, better nutrition—that are generally better delivered by home care—are at least as important."

Even though academics and lobby groups, such as Canada's Associatioin for the Fifty-Plus, have long pushed the idea, most provincial governments have been unwilling to commit sufficient resources to home care. Ontario recently capped home-care entitlements at a mere 60 hours a month. But when the services are available, they can help frail seniors remain independent. Eighty-year-old Bill Cummins of Toronto has been confined to a wheelchair since he suffered a minor stroke in 1997. His balance now is uncertain and his hearing has declined. But the former laboratory technician still gets around. Cummins is a regular at the Mid-Toronto Community Services frail-elderly program in a church a few blocks from his downtown home. A nurse came by three times a week after he was discharged from the hospital, but now

he only requires once-a-week help with cleaning and tidying up. A niece helps out with groceries and he calls her every day, just to check in. Cummins's large brown eyes are unclouded and he says there is really nothing he lacks: in additon to the social life at the community services centre, he has breakfast every day at a restaurant near his one-bedroom apartment, and once a month, he has supper with his Anglican priest. "If they told me I had to go into a nursing home, I wouldn't object," he says. "But as long as I can look after myself reasonably well, I'd rather live on my own."

Guy Proulx, director of psychology at Baycrest Centre for Geriatric Care in Toronto, has spent the better part of three decades working with the elderly. He says that while the system has many flaws, he is becoming more optimistic about the future, largely because there is greater understanding of the problems, and growing demand for change. "I have noticed that people now are much more acutely aware of the frustrations and the issues, and that is music to my ears," Proulx says. "We have an incredible challenge ahead of us, but this is much better than ignoring the problems."[1]

a. Home care is one solution—at least in part—to the eldercare crisis. One current problem with home care in Canada, according to the article, is the "wide disparities among the provinces." Explain what this means, and illustrate your answer with an example.

b. According to Malcolm Anderson, why does providing home care for senior family members hit middle-income earners especially hard?

[1] Patricia Chisholm, "All in the Family," *Maclean's*, 17 January 2000, 16–21. Adapted by permission.

c. According to Statistics Canada,

(1) what percentage of eldercare is provided by family members?

(2) approximately how many Canadians are caring for senior relatives either in their own homes or in the homes of the relatives themselves?

d. Why do so many adult children find providing home care for their aging parents so difficult?

e. According to Ernie Lightman, why is home care "the only option for the future"?

f. According to a recommendation from the National Forum on Health, a national home-care system would be a good idea. Explain the thinking behind this assertion.

g. From having read this article, what approach would you like to see Canadian governments take in dealing with the eldercare crisis that is onl just beginning? Give reasons for your answer.

Compare your answers with those in the Appendix, Section 1: Enrichment.

CONCLUSION

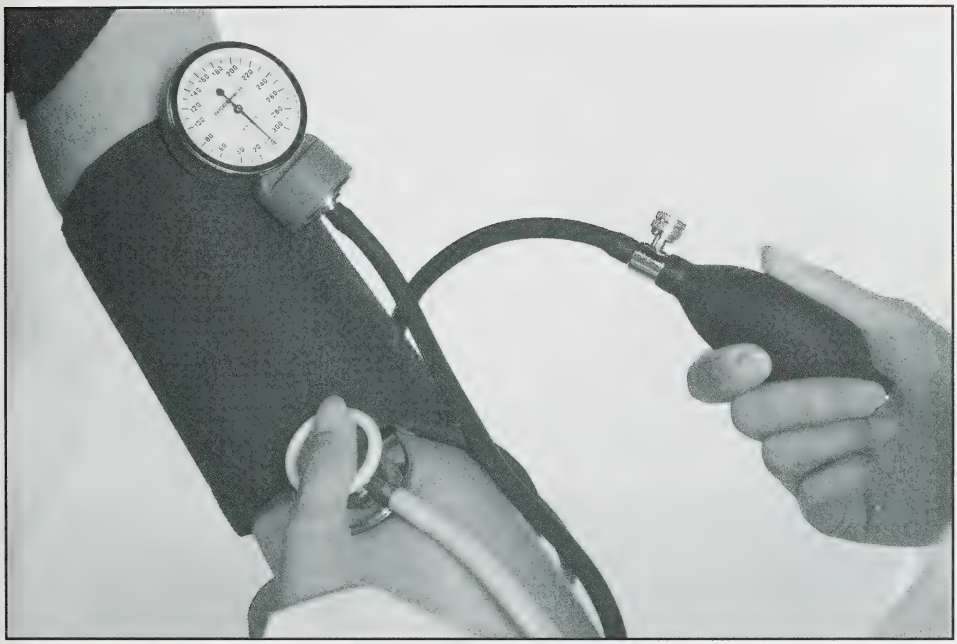
Section 1 of this course has given you an overview of some of the general issues involved in the task of home care. You've looked at such things as the impact of home care on family members, the stresses and strains on the primary caregiver, and the rights and responsibilities of both care-receiver and primary caregiver. You've also looked at community resources involved in delivering home care and the role of health-care professionals in assessing, recommending, and supporting home care for suitable patients.

The focus in this section has been on the family and the primary caregiver as opposed to the professionals like doctors and nurses, and support personnel who are all involved in home-care placements. But whether you find yourself caring for a family member in your own home or become a health-care worker involved in supporting and monitoring home-care situations, there are certain basic procedures that you'll need to have mastered in dealing with the care-receiver(s). In Section 2, the focus will be more practical, and you'll get a basic grounding in some of the procedures that you'll need to know.

ASSIGNMENT

Turn to Assignment Booklet A and do the assignment for Section 1.

Home Care—Getting Down to Business



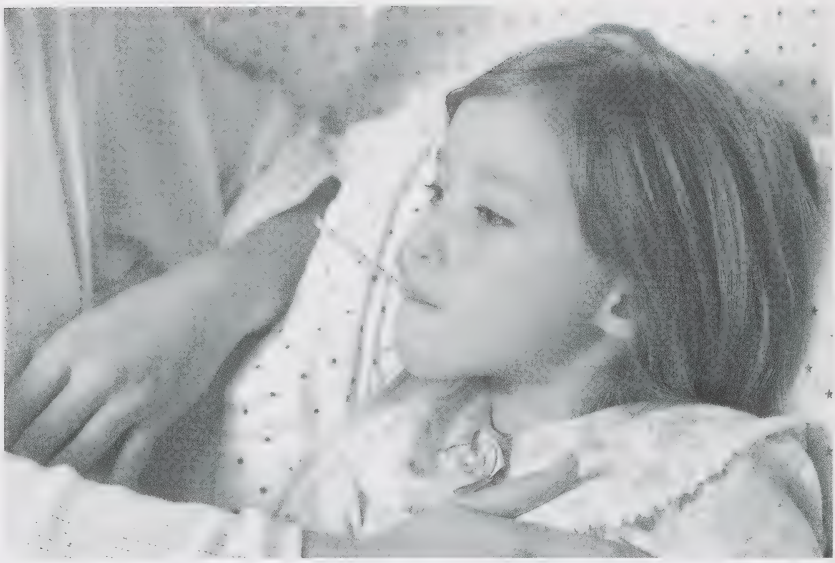
If you were caring for a relative at home or working as a home-care professional, would you know how to take and record a patient's vital signs? Would you know when—and how—to apply or change dressings on wounds and sores? Would you feel confident about alleviating discomfort in the patient or providing good nutrition?

Section 2 gives you instruction in some of the fundamentals of caring for a patient in the home. When you've finished this section, you should be able to demonstrate several basic procedures, explain the principles of sound nutrition, describe how to alleviate discomfort and avoid accidents, and explain how to adapt the home environment to accommodate the needs of a care-receiver.

SECTION 2

ACTIVITY 1

Some Basic Home-Care Procedures



The first section of this module introduced you to some of the issues in the area o home care. Now, however, it's time to roll up your sleeves and get your hands dir (well, actually, it's far better if you keep them clean, as you will soon see). In this activity, you'll be instructed in a few fundamental procedures useful if you're ever involved in providing home care.

Preventing the Spread of Germs

It probably sounds so basic that you're wondering why it's even mentioned in a course like this. However the importance of maintaining personal cleanliness and as much as possible, a germ-free environment can't be overstressed.

If you're caring for someone who's sick or injured, your first responsibility is to prevent spread of infection; simple jobs like washing your own hands must be taken very seriously.

Hand Washing

You no doubt think you know how to wash your hands. Often, however, people either don't bother or just give their hands a quick rinse. Before dealing with a patient a caregiver should follow these instructions:

- Remove jewellery from your hands and wrists.
- Adjust the water flow and temperature; use warm running water.
- Wet your hands under the running water. (Keep your hands lower than your elbows during washing, rinsing, and drying.)
- Lather your hands well with soap and warm water.
- Using a circular motion and friction, scrub the fingers, palms, back of the hands, and wrists for 10 or 15 seconds.
- Rinse your hands and wrists thoroughly.
- Dry your hands and wrists using a clean towel. From a hygenic point of view, a disposable paper towel is best. Dry from your finger tips to up past your wrists.
- Turn off the water using the towel to protect your hands from the contaminated faucet and then discard the towel.

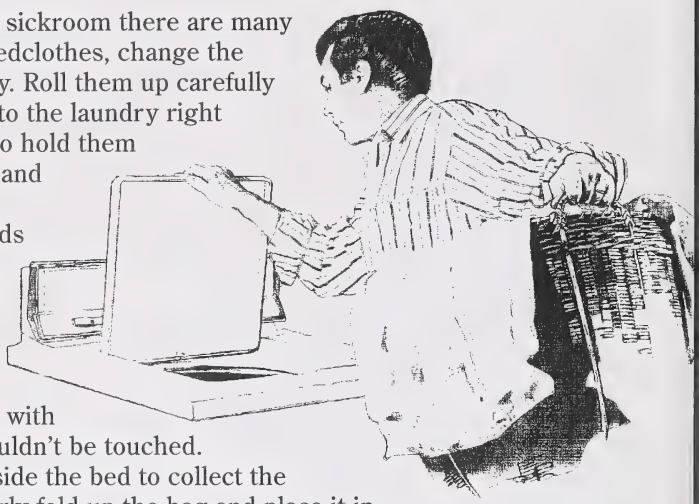
1. a. Be honest. Are you normally this careful whenever you wash your hands?

   b. Again being honest, approximately how many times a day do you ordinarily wash your hands?

Compare your answers with those in the Appendix, Section 2: Activity 1.

Cleanliness on the Job

Cleanliness begins with handwashing, but it certainly doesn't end there. It's important to remember that the immune systems of many care-receivers are weakened and they may be unable to resist an infectious virus or bacteria that might not affect a healthy person. Bearing this in mind, here are a few more basic rules of hygiene that will help prevent the spread of germs:



- Because in any sickroom there are many germs in the bedclothes, change the sheets regularly. Roll them up carefully and take them to the laundry right away. Be sure to hold them away from you and your clothing. Wash your hands after handling dirty bedsheets.

- Used tissues are also loaded with germs and shouldn't be touched. Place a bag beside the bed to collect the tissues. Regularly fold up the bag and place it in the garbage, replacing it with a new one. Wash your hands carefully after dealing with used tissues.

- Remember to cover your own mouth or move out of the room when feeling the urge to sneeze and cough around the care-receiver. Be sure to wash you hands if you sneeze or cough into them.

- Wash all dishes, glasses, and utensils immediately after they're used by a si person. Avoid touching the dishes as much as possible. You may need to rinse the dishes with boiling water and let them drip dry. Using a dishwashe should kill most germs if you stack the dishes in such a way that the hot water reaches all surfaces. Wash your hands after handling dirty dishes.

- A variety of barrier devices helps prevent the risk of spreading infection. Surgical face masks and disposable gloves, either vinyl or latex, are the mos common examples—hair nets, too, are appropriate in some situations. Glove are especially useful when changing dressings or performing any tasks where you could come into contact with the patient's bodily fluids or wastes Disposable gloves should be carefully discarded in a sealed or folded bag after each use. It is wise to ask the home-care nurse when a mask should be worn to prevent infection.

- Any implements such as thermometers and bed pans that come into contact with a care-receiver's bodily fluids or wastes must be carefully sterilized.

Teamwork

2. Can you think of any other basic rules that any caregiver should follow to avoid the spread of germs? If you can, brainstorm ideas with a classmate or friend.

Compare your ideas with those in the Appendix, Section 2: Activity 1.

Changing Dressings

Dressings on wounds are usually applied and changed by a health-care professional; however, it's something that a primary caregiver in a home-care situation may be called upon to do.

A dressing is applied to protect a wound from infection and to absorb the discharge from it. If the dressing becomes wet while the patient is being bathed or because of the wound's discharge, it should be changed. A dressing should also be changed if the discharge from the wound has a foul odour or if the dressing becomes loosened or dirty.

All dressings should be changed according to the directions of a medical professional. A brief summary of the steps normally involved is as follows:

- Assemble all the equipment you'll need before removing the old dressing.
- Wash your hands thoroughly before removing the old dressing (put on disposable surgical gloves if necessary).
- Remove the soiled dressing by pulling it gently from the corners. Discard it in a plastic bag (A paper bag isn't as satisfactory because any discharge on the dressing could leak through.) It may be necessary to moisten the dressing to remove it.
- Clean the area of the wound with soap and water or in some cases, with normal saline or sterile water. If required, swab the area with an antiseptic solution, working from the wound outward. Discard the swabs with the old dressing.
- Wash your hands again before applying the sterile dressing. Use clean swabs or appropriate sterile dressings supplied by the health unit or ones that have been purchased from a pharmacy.

- Lift the new dressing by the corners only and arrange it on the wound. Don touch any part of the dressing that might come into contact with the wound. If possible, handle the dressing with sterile tongs. If an ointment is to be applied, squeeze the ointment onto the dressing before applying the dressin to the wound. Be sure the tube does not touch the wound to contaminate it.

- Fasten the dressing in place with strips of adhesive tape and then apply a clean bandage to secure it in place.

- Put away all the materials. Seal the bag containing the old dressing and discarded swabs and put it in the garbage. Wash your hands once again.

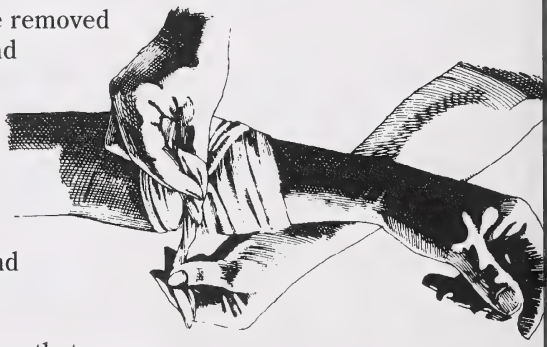
- Keep a record of each dressing change.

3. Based on the information you have just read, decide if you agree or disagree with each of the following statements. Correct each statement with which you disagree.

   a. Soiled dressings should be removed carefully by the corners and discarded in a paper bag.

   b. When cleansing a wound, use soap and water.

   c. To fasten the dressing in place, use adhesive tape and then apply a bandage.



   d. The part of a sterile dressing that comes into contact with the wound should not be touched with the hands.

   e. When changing a dressing, you should wash your hands before and after the treatment.

Compare your answers with those in the Appendix, Section 2: Activity 1.

Heat and Cold Applications

Another duty required in home care may be applying heat and cold treatments. Both heat and cold applications can be used to relieve swelling and pain. For serious injuries or conditions, it's essential to ask a health professional when to use heat or cold. In fact, it's a good idea to check with a professional even for less serious situations, just to be on the safe side. It's important to be sure that you're not going to make things worse. Bearing this in mind, it can generally be said that heat and cold will have the following effects.

EFFECTS OF HEAT AND COLD

Use of Heat	Use of Cold
• increases circulation	• decreases circulation
• increases perspiration	• reduces body temperature
• relaxes the muscles	• controls bleeding
• relieves tension	• decreases pain
• promotes the drainage of wounds	• decreases swelling

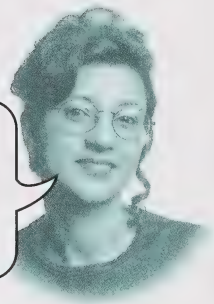
z bath: a bath en in a sitting ition in a all tub so that y the buttocks d hips are mersed

Heat and cold applications can be either dry or moist. Dry heat applications can be applied in the form of electric heating pads, electric blankets, or hot-water bottles. Moist heat is usually a more effective means of treatment than dry heat as the moisture will conduct heat faster and is more penetrating. Moist heat applications can be given in the form of warm baths, moist compresses, **sitz baths**, soaks, or steam inhalations. Breathing in moist air can relieve pain and reduce swelling in the mucous membranes lining of the nose, throat, and bronchial tubes. Steam inhalations are also prescribed for hoarseness, sore throat, and breathing difficulties; in some situations, they can also relieve coughing. Normally, steam-inhalation treatments involve using a mist vaporizer (or steamer).

Moist cold is generally applied by compresses made out of gauze or a folded wash cloth. Dry cold is most often applied by using an ice bag or chemical bag chilled in a freezer. If an ice bag is unavailable, it's easy to create one by inserting several plastic bags inside the other and adding crushed ice. A plastic food container can also serve the purpose if it's leak-proof; however, it probably won't be as comfortable. Do not apply these compresses directly to the skin.

My mother can go one better than that. I've seen her pull a bag of frozen peas or corn right out of the freezer and use it as a dry cold application.

That's a great idea in an emergency. But if the vegetables thaw out, I suggest that you always eat them shortly after; do not refreeze them for eating later. You can also, by the way, purchase bags that become cold through a chemical reaction as soon as you squeeze them.



Using heat or cold applications isn't terribly difficult, but you do have to know when each is appropriate. You must be careful not to overdo things. The St. John Ambulance and the Red Cross give the following cautions when applying heat or cold treatments:

- Never allow heating pads to get wet. This will prevent electrical shocks.
- Always use heating pads with a cover over them to prevent burning skin tissue.
- Never fold heating pads or pin them to something. This will prevent puncturing an electrical wire inside.
- Never use a heating pad on an unexplained pain such as a stomach ache. You may make things much worse.
- Never use a heating pad on an unconscious or paralyzed person because the person cannot indicate if it is too hot.
- Don't use a heating pad on someone suffering from poor circulation because there is a danger of burning. Rather, use a less aggressive method of heat application.
- Always examine a hot water bottle for weak spots and leaks before use.
- Always examine an ice bag for leaks by filling it first with water.
- Always discontinue the use of ice applications if the skin becomes blue, mottled, or numb.

4. Decide whether a heat or a cold application should be applied in each of the following situations, or whether neither type of treatment is appropriate.

   a. The care-receiver is sneezing and complains of being unable to get warm. Her feet are icy cold, and she feels chilled. She's not running a high temperature.

   b. The care-receiver has tripped on a mat and fallen. He feels pain in his ankle and it's beginning to swell slightly.

   c. The care-receiver is complaining of a pain in her back and doesn't know what caused it.

   d. The care-receiver is tense and has sore muscles from trying to walk too far with his new crutches.

Compare your answers with those in the Appendix, Section 2: Activity 1.

Checking for Vital Signs

The ability to check for vital signs is another skill needed by caregivers. This involves processes like assessing the care-receiver's pulse rate, respiratory rate, and temperature.

Taking a Pulse Rate

ulse rate: *the umber of times a erson's heart ats in a 60- cond interval neasured by eling the surge blood in the rteries)*

Taking a **pulse rate** isn't difficult, but to get an accurate reading, it must be done carefully. Carefully follow these steps:

- Have the care-receiver rest at least ten minutes before taking the pulse. Many factors can affect a pulse rate: among them are exertion, emotion, infection, heart disease, and illness. These cannot all be controlled, but exertion can be. It's important to be able to determine factors like this if an abnormal rate is detected.

- Place two finger tips on the inside of the care-receiver's wrist just above the base of the thumb to assess the radial pulse. Don't use your own thumb in taking the pulse because the thumb has a strong pulse and you may end up recording your own rather than that of the care-receiver.

- Press lightly on the artery that lies beneath your fingers so as not to stop the natural flow of blood.

- Using the second hand on your watch or a clock, count the beats carefully for a full minute. The number of pulse beats counted during a 60-second period is the pulse rate.

Waiting a full 60 seconds will give you the most precise rate, but you can get a reasonably accurate count by taking less time and multiplying. For instance, you could count for 30 seconds and multiply the number of counted beats by two to ge the pulse rate.

Another method of taking a pulse rate (carotid) is to place two finger tips on the major artery of the patient's neck, just below the jaw on either side of the windpip This method should be used with an unconscious patient and done on only one side of the neck or the other.

Taking a pulse rate is all very well, but, of course, it doesn't mean much if you don't know how to interpret it. All pulse rates should be recorded; that's how a pattern is established that can indicate if changes are taking place. Any irregularites like the following should be duly reported to a health-care professional:

- rate—a very fast or slow rate (For an adult, a normal rate is generally somewhere between 60 to 90 beats a minute. Rates are often faster for children.)
- strength—a pulse that's very weak or hard to find
- rhythm—a pulse with an irregular rhythm

5. Follow the preceding instructions and take your own pulse rate at different times of the day. Then take the pulse rates of family members or friends. Record your findings. How do people's rates compare? How much variation wa there in your own rate?

Compare your answer with the one in the Appendix, Section 2: Activity 1.

Taking a Respiration Rate

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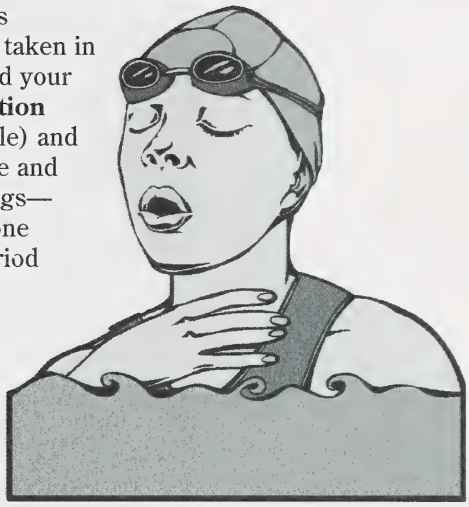


Respiration refers to *breathing*. A person's **respiration rate** is the number of breaths taken in a minute. When you breathe in (inhale) and your chest rises, it's called **inspiration**. **Expiration** occurs when you let out your breath (exhale) and your chest falls. Then there's a slight pause and the process begins again. These three things—inspiration, expiration, and pause—equal one respiration. Counting respirations for a period for one minute will give you a person's respiration rate.

Counting a care-receiver's respiration rate is very simple: simply observe the patient breathe for a minute and count the number of respirations. One thing to note however, is that if a care-receiver is aware that you're counting the respirations, the rate may change. One way to avoid this is to learn to check the patient's respiration rate while taking the pulse. Simply continue holding the wrist after taking the pulse, but count breaths instead. The patient, thinking that you're still counting heartbeats, won't become self-conscious about breathing.

Just what is a normal respiration rate? For an adult, the average rate is about 16 to 20 breaths a minute. If the rate is more than 25, it's said to be *accelerated*; an accelerated rate should be reported. Likewise, a rate of less than 12 breaths a minute should be reported too.

While taking a respiration rate, you should also note whether the care-receiver's breathing is deep or shallow, difficult or easy. Do you hear any wheezing, gurgling, or problems in breathing? Is the rate irregular? If so, these observations should be noted and reported to the health-care professional in charge of the patient as soon as possible.

6. Count your own respiration rate several times during the day.

    a. How much variation do you note?

    b. To what do you attribute this variation?

Compare your answers with those in the Appendix, Section 2: Activity 1.

Having your temperature taken is a procedure familiar to almost everyone. A clinical thermometer is a thermometer designed to take a patient's temperature and is often found in the home.

The clinical thermometer you may be familiar with is one designed to be used in the mouth. Body temperatures can also be taken rectally; normally this is done with a special **rectal thermometer**. Sometimes it is appropriate to take temperature by placing the thermometer in the armpit or groin. As well, some thermometers (tympanic thermometers) can take a quick digital reading when placed in the patient's ear or just against the skin.

▼

rectal thermometer: *a fever thermometer designed to be inserted in the rectum*

oral thermometer: *a fever thermometer designed to be inserted into the mouth*

▲

The traditional **oral glass thermometer** may still be used in some hospitals and homes. However, sometimes oral thermometers wouldn't be appropriate: for young children or for a person unconscious or unable to breathe through the nose, for instance. If you go into a health-care facility, you may see a variety of thermometer types: electronic thermometers with disposable tips, plastic or paper disposable thermometers, and digital ones. Be very careful not to break a glass thermometer especially if it has mercury in the fluid column. Mercury is extremely toxic.

Precisely how should you go about taking a care-receiver's temperature orally? Here are the steps you should follow when using a traditional glass thermometer:

- Ideally, the care-receiver shouldn't eat, drink, smoke, or take a bath for at least 20 minutes to half an hour before the temperature is taken. These activities can affect the reading to some degree.

- Wash your hands.

- Assuming that you're using a normal glass thermometer, sterilize it with alcohol, and rinse it with cool tap water. Then, holding the end away from the bulb firmly between your thumb and forefinger, shake it until the fluid in the column drops below the marker indicating normal body temperature.

- Place the bulb end of the thermometer between the lips and under the tongue of the care-receiver. (If using a rectal thermometer, insert it gently into the rectum.)

- Remind the care-receiver to keep the lips closed and not to bite down. It's best to keep an eye out to see that the thermometer stays in place.

- Leave the thermometer in place for at least three minutes. It can take eight minutes to register an oral temperature accurately, but normally a reasonably reliable reading can be obtained in three to four minutes. (A temperature taken with a rectal thermometer will give a slightly higher reading than one taken orally.)

- Gently remove the thermometer and turn it so that the numbers are toward you. In a glass thermometer, the coloured fluid column ends at the number indicating the person's temperature. Reading a thermometer can take a bit of practice. Be sure you have a good light, and rotate the thermometer until you see the fluid column. Then note and record the temperature.

- Sterilize the thermometer, put it away, and wash your hands.

7. What is the normal human body temperature? You probably have learned it in school, but you may have forgotten. Most fever thermometers have a marker arrow if you need to check.

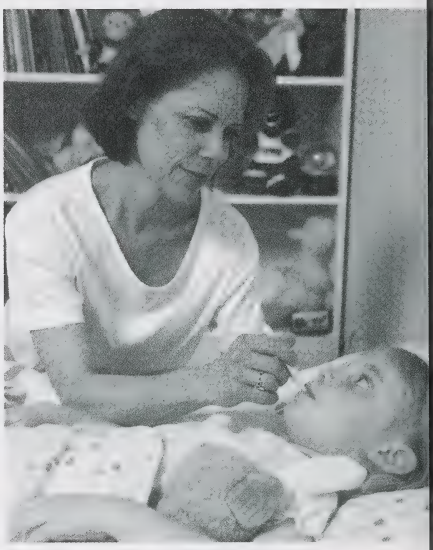
Compare your answer with the one in the Appendix, Section 2: Activity 1.

When should you take a care-receiver's temperature? If the person is ill, it's a good practice to take it every few hours and record—and compare—the results. You should definitely take the temperature if the patient

- is cold or shivering
- feels, or complains of, being hot
- is flushed or sweating
- is restless or in pain
- complains of headaches

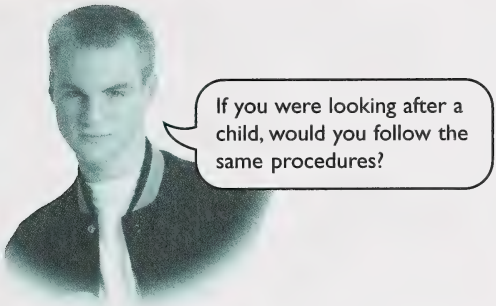
If you record a temperature of 38.3 degrees Celsius, or higher, continue taking the patient's temperature every half hour, keeping a careful record. Bear in mind that fever is normal during an infection and can help a patient fight the sickness; however, a high fever that continues for several days can be harmful and should probably be reduced. Some things you can do to help reduce a fever are as follows

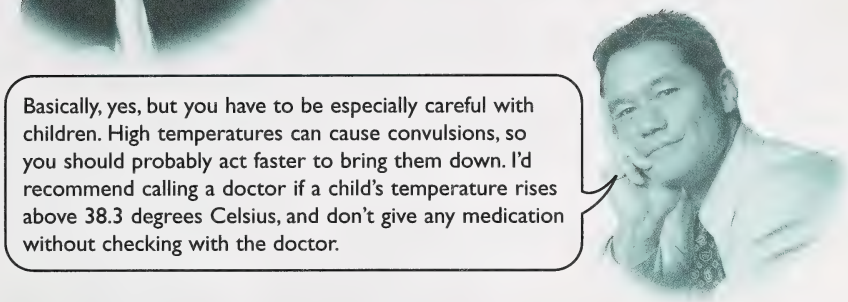
- Remove extra clothes and bedclothes (but don't let the patient become chilly).
- If you know that the patient is permitted to take an ASA tablet, use it according to the recommended dosage.
- Give the patient a sponge bath with tepid (lukewarm) water.
- If the fever continues or rises, consult a health-care professional such as a doctor.
- Meanwhile, have the care-receiver drink lots of liquids.



One of the best ways to bring down a fever is to give the patient a tepid sponge bath. Here's how to do this. Fill a basin with lukewarm water and get several wash cloths. Immerse the cloths in the water, wring them out (but not too much), and bathe the patient's body with long, even strokes. Then place the damp cloths on areas of the body where the blood vessels are close to the surface, such as on the forehead, under the arms, and around the groin, abdomen, wrists, and the back of the neck. Change the cloths frequently for a period of up to 20 minutes. Use a sheet or towel to cover the care-receiver's body to prevent shivering. Shivering is the body's attempt to warm itself.

When the bath is over, dry the patient thoroughly and take another temperature reading. If the temperature hasn't dropped, try repeating the bath. If the temperature doesn't drop within one hour, contact a medical professional.





8. Indicate whether you agree or disagree with each of the following statements. Correct the ones with which you disagree.

   a. A fever must always be brought down at once.

   b. All human beings have the same normal body temperature.

   c. Cold, damp cloths or ice packs on places like the forehead, groin, and armpits are a good way of bringing down a fever.

   d. An oral thermometer takes several minutes to give an accurate reading.

   e. Eating hot food can increase a person's body temperature for a while.

   f. A patient should bite down on a thermometer to keep it in place.

9. If possible, practise taking your own temperature and the temperature of family members. Keep a record for a few days and note any changes. The thermometer must be cleaned and sterilized between uses. Use soap and water to clean a glass thermometer. Sterilize it by soaking it in alcohol. Be very careful not to break it, especially if it has mercury in the fluid column. Follow the manufacturer's instructions to clean a digital thermometer.

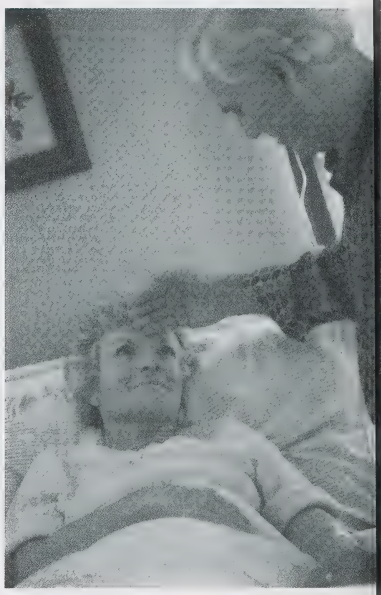
Compare your answers with those in the Appendix, Section 2: Activity 1.

In this activity, you've learned some procedures involved in basic home care for sick or injured care-receivers. Now you know something about taking pulse rates, respiration rates, and body temperatures; applying heat and cold treatments, changing dressings, and maintaining hygienic conditions. These hands-on procedures must be practised to be learned properly.

A person involved in home care also needs to know how to keep a patient comfortable. The next activity will help you with this.

ACTIVITY 2

Keeping the Care-Receiver Comfortable



Have you ever been confined to your bed for several days and unable to change your position easily? If so, you'll know just how uncomfortable it can be. Even a soft, warm bed with lots of pillows can become painfully uncomfortable when you seem stuck in one position. Sometimes it simply hurts too much to move.

Many care-receivers suffer discomfort on a regular, long-term basis. As a result, it's important for caregivers to be able to do what they can to keep their patients as comfortable as possible. While a caregiver may rely on nurses, nursing assistants, and personal support aides to do some of the regular home-care tasks, you can't call in a professional every time the person in your care needs to be shifted, dressed, or moved from a bed to a chair. In this activity, you'll look at a few basic techniques that can help a home-care receiver be as comfortable as possible.

Shifting and Transferring Patients

Many home-care patients spend much of their time in bed; therefore, it's important to make the bed as comfortable as possible. If the patient's position is lying on the back because of a medical condition, support the head with one or two pillows. Keep the head, shoulders, and hips in a straight line, and try to keep the knees slightly bent by placing a small pillow under the patient's thighs just above the backs of the knees. A small, flat pillow can be used to support the small of the back. Lie the arms next to the body with the forearms bent toward the body. Turn the thumb of each hand toward the palm and keep the fingers in a flexed position.

Your care-receiver may enjoy a side-lying position for a few periods each day if the medical condition permits it. If the patient is unable to achieve this manoeuver independently, here's one method to follow:

- Standing beside the bed, cross the patient's far leg over the leg nearest you.
- Cross the far arm across the chest, bending the elbow and bringing the hand up toward the head of the bed.
- Bracing your thighs against the bed, place one hand on the patient's shoulder and the other on the hip.
- Now roll the patient toward you, slowly and smoothly.
- Assist the patient to bring the upper leg toward you, bent comfortably at the knee.
- Go around to the other side of the bed, place your hands under the patient's hips and shoulders, and gently pull the patient toward you.
- Place a pillow behind the back to act as support; tuck it in place securely. Consider using pillows to support the upper leg and upper arm as well.

[1]

[1] Barbara R. Hegner and Esther Caldwell, *Nursing Assistant*, 7th ed. (New York: Delmar Publishers Inc., 1995), 203. Reprinted by permission.

1. Get a friend or family member to play the role of a patient unable to move, and practise this technique. Try to be as smooth and gentle as you can.

A primary caregiver should ask the home-care nurse about suitable positioning for the care-receiver. Using those instructions, it's best to develop a regular routine of turning a bed patient at least once every four hours. Usually a patient is turned from one side to the back and then onto the other side. Sometimes a patient can be placed on the stomach for a while as well to relieve a sore back or buttocks. If so, turn the head to one side, and place a small pillow under the abdomen at the level of the diaphragm (at the bottom of the ribcage). The pillow will give support to the spine. You should also place a pillow under the patient's lower legs to elevate the toes and to permit a slight flexing of the knees.

Your care-receiver may want to sit up in bed, depending, of course, on factors like age, type of injury or illness, and the stage of recuperation. If the patient requires assistance, follow these steps:

- Stand beside the bed, facing the head of the bed.
- Lock your arm with the patient's nearest arm so you're both holding tightly.
- Support the patient's head and shoulders with your other arm.
- Pull the patient into a sitting position.
- Support the patient's back with pillows.

If you're helping a patient move toward the head of the bed (bed patients do tend to slouch down), help the patient bend the knees, and then follow the preceding steps. Then, when you're pulling up, the patient can lift the buttocks and push with the heels as much as possible. Use a count of three so you both get to work at the same moment. If the patient can't help in this way, get another person to stand on the opposite side of the bed. Then, on a count of three, you can both lift the hips and shoulders of the patient up toward the head of the bed.

When I visited my Aunt Jean in the hospital with her broken hip, she had an overhead bar for sitting up. She just reached up, grabbed hold, and hauled herself up. She claimed that she developed some real upper-body strength by doing that.

That's right. Those trapezes, as they're often called, are very handy, and beds can be fitted with them in the home. But elderly or weakened people frequently can't make a great deal of use of them.

2. With a friend or family member acting as patient, practise moving this person into a sitting position and up to the head of the bed.

If your care-receiver is able to sit in a chair to read, watch television, or simply to have a change of position, another challenge presents itself: how to move the person to the chair. If the patient is heavy or unable to help you much with the operation, you'll probably need a **transfer belt**—a wide safety belt that goes around the care-receiver's waist and gives the care-giver something to hang onto. (See the photograph that follows.) The instructions that follow assume that the move from bed to the chair can be accomplished without the use of a transfer belt. If a belt were being used, the only real change is that the caregiver would hold the belt rather than the patient's waist.

***ransfer belt:** a vide, heavy belt sed around a atient's waist to ransfer him or er from one urface to another*

- Have the chair ready beside the bed; if possible, have it braced against a wall If it's a wheelchair, be sure the locks are on the wheels.
- Help the patient swing the legs over the side of the bed while assisting him or her into a sitting position.
- Allow the patient a few moments to adjust to the new, upright position.
- Put slippers with non-skid soles on the patient.
- Gradually, manoeuver the patient farther forward toward the edge of the bed.
- Stand in front of the patient and hold onto the patient's waist.
- Have the patient hold your shoulders or clutch the edge of the bed on either side of his or her legs.
- At the count of three, have the patient push and pull up into a standing position while you provide whatever support and help is needed.
- Keep the patient standing for a few moments to get stabilized. Hang on tightly.
- Help the patient step or pivot around until facing the front of the chair. Tell the patient not to sit until the edge of the chair seat can be felt firmly touching the backs of both legs.
- Have the patient sit by bending forward, and then sitting, reaching for the arms of the chair in the process. You should continue to provide support around the waist.

3. With the help of a friend or family member, practise this technique. It will be difficult for the person playing the patient to be as helpless as many home-care patients are, but do your best.

4. Tell whether you agree or disagree with each of the following statements. Correct any with which you disagree.

   a. When helping patients move to a chair, they should never be allowed to stand upright.

   b. Patients should be allowed to sit for a few moments on the edge of the bed before standing up.

   c. Patients shouldn't try to sit in a chair until they can feel the chair with at least one leg.

   d. When helping the patient move to a chair, make sure the chair isn't too close to the bed.

[1]

Compare your answer with the one in the Appendix, Section 2: Activity 2.

[1] Barbara R. Hegner and Esther Caldwell, *Nursing Assistant*, 7th ed. (New York: Delmar Publishers Inc., 1995), 203. Reprinted by permission.

Sitting up, for someone who's been in bed for a long time, can be enjoyable, but it's usually something that should be approached gradually. As a rule, don't allow a care-receiver to sit up for more than 15 to 20 minutes the first time. When stronger, your care-receiver might be able to make use of a walker to lean on while attempting to take a few steps. If you're helping a patient to walk a longer distance, be there to offer support under the arms or around the waist.

5. Many care-receivers recovering from an injury to a leg, hip, or foot eventually learn to use crutches. Have you ever received an injury that resulted in your using crutches? Try to explain the process used to get from a sitting position onto crutches.

Compare your answer with the one in the Appendix, Section 2: Activity 2.

Dressing a Patient

The time will come for a patient who is recovering from sickness or injury to get back into normal clothes. Sometimes a home-care patient who has been in bed for a long time will feel better just by getting dressed, even if it's not yet time to be getting up and about. An operation as simple as this can be a challenge for a caregiver.

To help a bed patient put on a pair of pants, follow these steps:

- Pull the pants up over the feet and as high up the legs as possible.
- Help the patient turn onto the side as described earlier.
- Pull the free half of the pants up over the hip.
- Turn the patient onto the other side and pull up the other half of the pants.
- Turn the patient back into position and do the pants up.

Putting a shirt or sweater on a bed patient is normally easier. Once you've raised the person into a sitting position as already described, it's generally not a serious problem getting the garment on. You'll likely have to help guide the arms through the sleeves. Of course, anyone learning to work with bed patients will be trained in precise ways of getting every conceivable type of garment on and off the patient and over intravenous tubing with the least pain and inconvenience to the patient.

6. Try to put on a complete set of clothing while lying in bed. Try to imagine that you can't raise your legs or hips much. What movements did you find difficult?

Compare your answer with the one in the Appendix, Section 2: Activity 2.

Preventing Pressure Sores

pressure sores: *dermal ulcers or bedsores—sores that occur on the skin when circulation is slowed down by extended pressure or friction on a part of the body*

Patients who lie in bed for a long time are likely to be at the risk of developing **pressure sores**. You'll be looking more closely at skin problems like these in Section 3, but since you are thinking about care-receivers' comfort in this activity, mention should be made of them.

Pressure sores, commonly called *bed sores*, can occur in any patient, but they are most common in elderly, obese, and very thin patients, especially when they're unable to move. The pressure that results on the skin when a patient lies in one spot interferes with circulation, and a sore results. Often pressure sore can become large and deep, and they can cause a patient a great deal of discomfort.

It's much easier to prevent pressure sores than to cure them. Caregivers interested in the comfort of their care-receivers should always be on the lookout for sores and should take steps to prevent them. Here are some steps that help:

- See that the patient changes position every few hours if possible.
- Make sure the bed sheets are clean, dry, and smooth.
- Change the patient's pyjamas or clothing whenever it becomes soiled or wet.
- Wash the patient's skin regularly and keep the areas between the folds of the skin clean and dry.
- Massage regularly areas at risk on the patient with creams or lotion.
- Use pillows, pieces of sheepskin, and sponge foam to protect the pressure-bearing areas.
- Make sure the patient drinks enough fluids and maintains proper nutrition.
- Help the care-receiver with exercises to improve circulation.

About those exercises–if patients are so immobile that they get bed sores, how on earth are they supposed to do exercises?

Good question. It's always important for anyone confined to a bed to get exercise to keep the muscles as strong as possible and the circulation functioning properly. A physiotherapist or occupational therapist will show the caregiver how to assist the patient. The exercises may, for instance, be as simple as pointing the foot and then bending it back to prevent blood clots in the leg; but whatever the patient is able to do should be done.

7. Imagine that you were lying in bed recovering from an injury that made it difficult to move your leg—a broken hip for example. Suggest an exercise routine that would allow you to flex your leg muscles, mobilize your joints, and keep the circulation in your leg flowing as it should. Try the exercises yourself; how possible or useful do you think they would be?

Compare your answer with the one in the Appendix, Section 2: Activity 2.

Massaging the Patient

Massaging a care-receiver can provide relief from soreness. You should use a cream lotion that doesn't contain alcohol (which dries and hardens the skin). It's especially important to avoid lotions with alcohol if the patient is elderly. The skin of an elderly person, particularly one who tends to have poor nutrition, may be very dry.

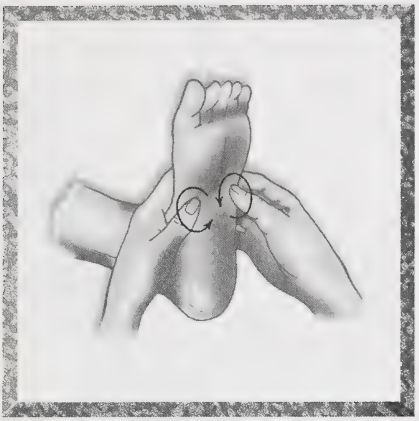
There are many types of massage, from a highly specialized therapeutic massage to simple relaxation massages. What follows is a set of steps you can follow to give a simple, relaxing, and comforting back rub to a bed patient:

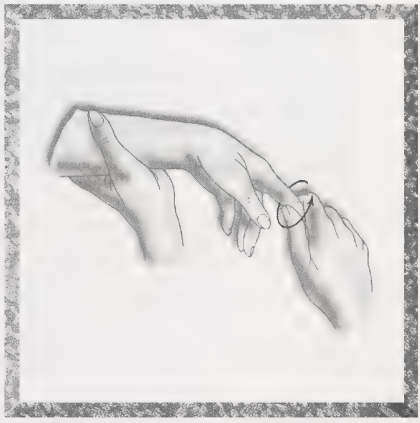
- Help the patient lie on one side or, if possible, on the abdomen.
- Apply lotion (heated first in a basin of warm water) to your hands and place them at the base of the patient's spine, your fingers pointing toward the neck
- Using only the palms of your hands, rub upward on each side of the spine with long, smooth strokes. Go right up to the shoulders.
- Use a series of circular motions to return your hands to the base of the spine Use more lotion as needed and repeat this process several times.
- Using large, circular motions, massage the sides of the back and the buttocks. Pay special attention to all areas that take most of the person's weight when lying down—for instance, the shoulder blades, the hip bones, and the base of the spine.

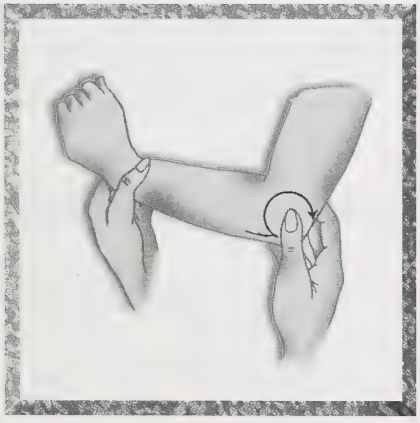
8. Practise this back-massaging technique on a willing friend or family member and ask for feedback. Then have your partner try it on you. What do you think

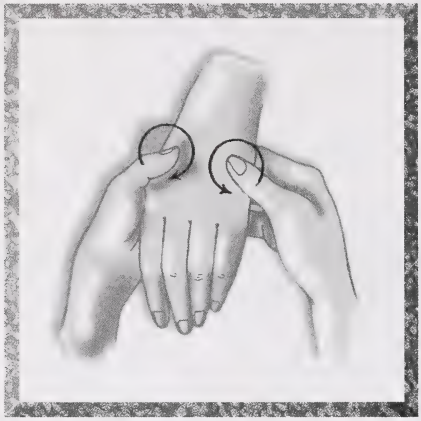
Compare your answer with the one in the Appendix, Section 2: Activity 2.

If a care receiver has discomfort in other parts of the body, you may be able to provide relief there with massage as well. The diagrams that follow illustrate some basic techniques that can be used to massage hands, arms, and feet. The arrows indicate the direction you should be moving your fingers or thumbs or rotating the affected body part.









9. Try these massage techniques on a friend or family member and have this person try them on you. Naturally, if you aren't suffering from joint pain or other discomfort, the results won't be as noticeable as they otherwise would be, but the experience of being massaged should relax tense muscles and relieve stress.

Compare your answer with the one in the Appendix, Section 2: Activity 2.

In this activity, you've had a very brief look at some of the things a caregiver can do to make a care-receiver more comfortable. Of course, this only introduces the basics; anyone looking after a bed patient, either as a health-care professional or a primary caregiver in a home-care situation, must master these skills and many more as well.

Another thing a caregiver has to think about is how to keep the care-receiver healthy, and this means, among other things, maintaining proper nutrition. You'll be looking at this issue in the next activity.

ACTIVITY 3

Providing Good Nutrition

Think back to the last time you were really unwell—perhaps with a flu or something equally unpleasant. Do you remember the effect it had on your appetite? Sickness can destroy people's interest in food, and lying in bed certainly doesn't stimulate the appetite much either. Yet wholesome, nutritious food is just as important for sick or injured people as for anyone else—probably more so.

Anyone caring for a person in the home knows how difficult it can be making sure that the care-receiver eats properly. It's important that meals be pleasant and tasty; it's also important that they be nutritious and varied. If there are certain types of foods the patient must avoid or must have, another challenge is added.

I remember when I was in hospital with my broken leg. It seemed to me that the chief concern of the people supplying my meals was that I got lots of fibre–prunes, bran muffins, and all that stuff.

That's very true. One of the big problems with lying still in bed for any length of time is that you can easily become constipated. It's important to make sure bed patients get lots of high-fibre food to act as a natural laxative.

Some General Rules

Just how are caregivers supposed to supply their care-receivers with a varied supply of interesting, appetizing, and healthy foods? Following are a few general guidelines that should get you started:

- Prepare and serve meals that follow the basic recommendations of *Canada's Food Guide to Healthy Eating.*
- Serve food your care-receiver enjoys and can manage swallowing.
- Provide lots of fluids.
- Serve a variety of foods rather than the same few meals over and over.
- Use a variety of foods with different textures, tastes, and colours.
- Serve lots of foods with a high fibre content.
- Don't overwhelm the patient; tailor the size of the portions to the individual's age, condition, and appetite.
- Ask the care-receiver for input when you plan your daily menu.

1. *Canada's Food Guide to Healthy Eating,* a small, easily understood brochure published by the federal Department of Health, gives you the recommended number of servings of different food groups for maintaining optimal health. Properly balanced meals containing grain products, vegetables and fruits, milk products, and meat or meat substitutes will provide a care-receiver with the basic nutrition everyone requires. If you have access to the Internet, you can check out *Canada's Food Guide* doing a search using the search words "Canada's Food Guide."

   You may send away for a copy of this guide at this address:

   Publications Health Canada
   Ottawa, Ontario K1A 0K9
   Telephone: (613) 954-5995

   It is usually also available at Health Units and hospitals.

Special Diets

Individual care-receivers frequently have special dietary needs. One person, for example, may have a great deal of trouble chewing or swallowing food while another must avoid fats, refined sugars, or foods containing gluten. One patient may need to lose weight while another needs to put it on. Naturally, all the different diets a patient might need can't be discussed here, but what follows are a few representative examples.

A patient with a wasting illness, burn, or fracture needs a high-protein diet to help build up body tissues. Though a dietician should be consulted for each case, in general, a person needing protein should receive a diet high in foods like meat, fish, and **legumes**.

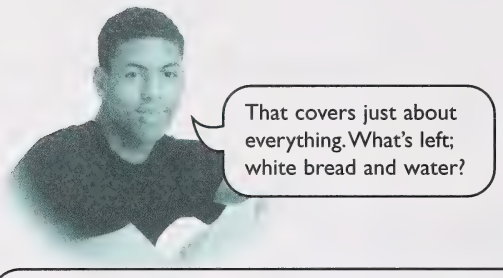
gumes: *foods e peas, beans, d lentils, which e all seeds of nts of the d-bearing mily*

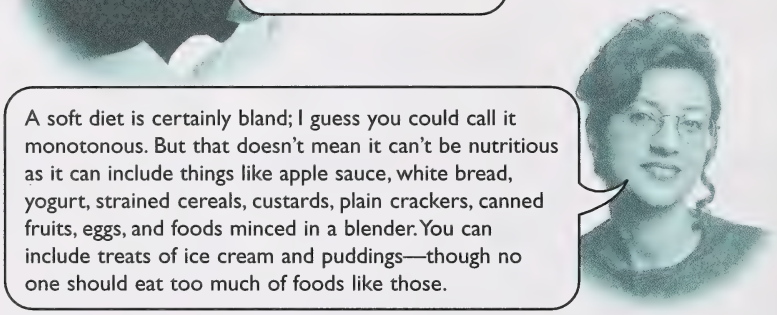
A patient who can't chew or swallow properly or who has serious digestive problems may need a liquid diet. If a liquid diet is to be followed for more than five days, it should definitely be supervised by a health-care professional. Liquid diets normally include all foods that are liquid at room or body temperature as well as some foods that have been liquified with a kitchen blender. Patients on liquid diets usually require six to eight meals a day, one every two to three hours. As well, these patients generally require supplements, especially protein, iron, and vitamin supplements.

2. Imagine that you had to provide meals for a care-receiver on a liquid diet. Suggest some foods you could provide. Try to come up with at least **five or six** ideas.

Compare your answer with the one in the Appendix, Section 2: Activity 3.

Patients who can't chew, swallow, or digest food well but who want more variety than just liquids may require a soft diet. As its name suggests, a soft diet is comprised of easily digested foods that are plainly prepared and cooked. Spices along with some salads, coarse vegetables such as celery, raw fruits (except for bananas and juices), coarse breads and cereals, nuts, fatty foods, and rich pastries are all to be avoided.





Some care-receivers have to limit their calorie intake while others must try to put on weight. Patients in these categories should be under the care of a nutritionist. Overweight patients will ordinarily be given a fixed number of calories to be consumed each day, and the total amount of foods eaten will be closely monitored. By contrast, weight-gaining diets consist of foods high in calories. Excessive snacking is to be avoided because this will interfere with the mealtime appetite and it's usually at meals when the most nutritious, balanced foods are eaten.

As noted earlier, constipation is a frequent problem with patients confined to a bed or who otherwise are unable to move around much. A high-residue (or high fibre) diet is important for care-receivers who are having problems eliminating waste from their systems. Foods included in a high-residue diet include foods high in fibre like prunes, fresh fruits and vegetables, whole-wheat bread, bran muffins, and high-fibre cereals.

3. Now that you've been thinking about diet and nutrition a bit, consider your own diet? How healthy do you think it is? Ask yourself questions like these:

   - Is it balanced among the four food groups recommended by *Canada's Food Guide* (grain products, fruits and vegetables, milk products, and meat or meat substitutes)?
   - Are rich, fatty, and sweet foods kept to a minimum?
   - Do you eat high-fibre foods such as fruits, vegetables, and whole grains?
   - Do you avoid highly processed foods as much as possible?
   - Do you eat a wide variety of fresh fruits and vegetables so as to get the vitamins and minerals your body needs?

Compare your answers with those in the Appendix, Section 2: Activity 3.

Making Meals Enjoyable

Making mealtimes enjoyable for care-receivers is also an important task for caregivers. If meals are pleasant, enjoyable experiences, a patient is more likely to eat well. Here are a few tips that help in this process:

- Prepare an attractive food tray. Arrange the food nicely, and consider how colours can complement each other. Use a variety of table mats or napkins to add interest to the tray.
- An overloaded plate isn't necessarily appealing and may discourage a care-receiver from eating. If time permits, consider serving four or five smaller meals during the day rather than three large ones. Keep portion sizes suitable for the age and appetite of the patient.
- Help your care-receiver with hand-washing before eating. Bear in mind that the patient may want to have his or her hair combed and to use the washroom before the meal arrives.
- Try to serve meals at a table; but if the care-receiver can't get out of bed, try to make things as convenient as possible. Consider buttering bread or cutting up meat before serving the tray.
- The patient and the bed may need to be protected from food spills, but be sensitive to things like insisting on a bib, which the patient might find insulting. Consider buying large napkins instead.

4. Suggest at least **three or four** things you could do to make a meal tray attractive.

Compare your answer with the one in the Appendix, Section 2: Activity 3.

Feeding a Patient by Hand

It's important for care-receivers to feed themselves if possible. If this isn't possible and you have to do the job, here are some hints.

- Wash your hands before feeding.
- Learn your patient's food preferences and offer them first.
- Protect the patient's clothing and bedding from spills.
- Try to have the patient sit up in bed if possible.
- Use the utensils you'd normally use for the food being served.
- Feed the patient slowly and carefully. Serve bite-sized portions.
- Fill spoons only two-thirds full to minimize spills.
- Use a straw or a cup for cool or cold liquids, whichever the care-receiver finds easier. Never use a straw for hot liquids.
- Try to carry on a natural conversation or listen to soothing music throughout the meal.
- Don't overfeed the patient. Consider recording the quantities of food and liquid intake to give you an idea of the portion size you should be serving.
- When feeding someone who is blind, inform the patient and allow the utensil or food to touch the lips to let the patient know food is being served and what the food is.
- If a blind patient can eat independently, arrange the tray in a clockwise manner. Refer to each item on the tray in relation to its position on the clock. For example, the cup may be at one o'clock and the dessert at nine o'clock. Always be consistent in the arrangement of the tray.

5. a. If you can find a friend or family member willing to help, practise serving this person a meal in bed pretending that your "patient" can't eat independently. Another time, blindfold the patient and serve a meal assuming that the patient is blind. Take careful note of the problems you encounter.

   b. It's important for caregivers to understand the frustrations of care-receivers. To learn how it feels being fed, repeat question a., but this time take the part of the patient yourself. Note carefully the frustrations and annoyances you feel as you're being fed.

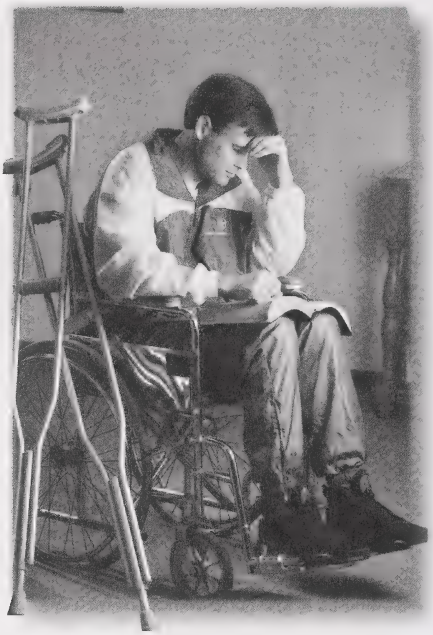
Compare your answers with those in the Appendix, Section 2: Activity 3.

In this activity, you've looked at some of the general principles involved in providing nutritious meals for care-receivers. One last point you should note is that many communities have a "Meals on Wheels" program that will deliver hot, nutritious meals right to the doors of people unable to cook for themselves. These meals may be cooked at the community hospital, and they are designed to meet the dietary needs of individual care-receivers. This service can lessen the responsibilities of a caregiver either on a regular basis or once in a while. Another option is to have relatives, neighbours, or friends, bring in meals periodically to give the primary caregiver a break.

Nutritious meals are an important part of home care, but there are many other things a caregiver must bear in mind when trying to provide a healthy, pleasant home-care experience for a care-receiver. One of these things is making the actual physical environment safe, pleasant, and functional. This is what you'll be looking at in the next activity.

ACTIVITY 4

Adapting the Environment



JIM WHITMER PHOTOGRAPHY

Have you ever been confined to your bed for a few days or more because of illness or an accident? Or have you spent time in hospital? If so, you'll know how quickly you can become sick of looking at those same walls, the same furniture, and if you're lucky enough to have a window in sight, the same view outside. You'll probably understand how important it is t have the room conveniently set up to accommodate a bed patient. Are the thing you need within reach? Is the room near enough to the rest of the house so you ca call for help if you need it? Is the room to hot or cold? Are there drafts? Is it near a bathroom?

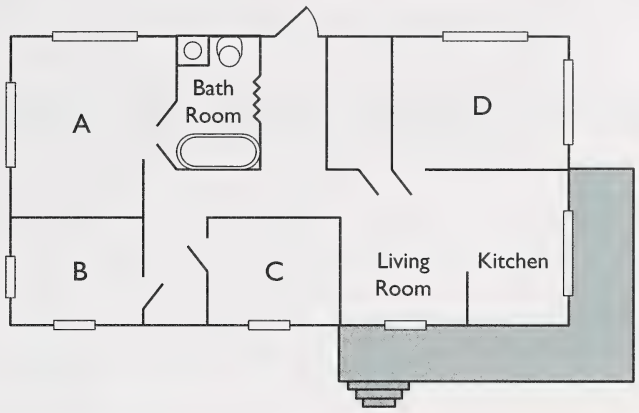
In this activity, you'll look into these matters. When you have finished the activity, you should be able to analyze a room for its suitability for a home-care patient and recommend changes to it that would make it comfortable and functional for a care-receiver.

Setting up the Room

Since many care-receivers are either confined to a bed or spend much of their tim there, the physical surroundings of the bedroom may be very important. What follows are some of the suggestions provided by organizations like St. John Ambulance on how to set up a sickroom.

Ideally, the sickroom should be in a part of the house from which the patient can be easily heard. It should also be near bathroom and kitchen facilities, if possible

1. Look at the floorplan that follows for a one-storey home. Which room (A, B, C, or D) would be the best for providing home care? Give reasons for your answer.



Compare your answer with the one in the Appendix, Section 2: Activity 4.

In setting up a bedroom for home care, be sure it includes the following furniture:

- a bed
- a chest of drawers for clothing and a surface area for nursing equipment
- a comfortable armchair that provides good back support
- a bedside table to hold personal items such as comb, mirror, and pen and paper (all preferably in a drawer) and (on top) a bottle of fresh drinking water, a drinking glass, a box of tissues, a radio, and a small bell for summoning help, all within easy reach of the patient
- a reading light that can be turned on and off by the patient (if capable) without getting out of bed
- a strong, stable footstool if the bed is high and the patient is allowed to get out of bed at night
- carpeting on the floor that will reduce noise and lessen the possibility that the patient will slip and fall

2. Can you think of anything else to add to this list? Try to come up with at least one or two useful ideas.

Compare your answer with the one in the Appendix, Section 2: Activity 4.

Being sick or injured is no fun; therefore, it's important to make the sick room as cheerful as possible. To cheer the care-receiver up, you might want to add pictures to the walls and put plants in the window and on the bureau. If possible, set the room up so the patient can look out the window, but be careful that bright sunshine doesn't cause discomfort. Use positioning, curtains, and blinds to ensure that the patient has a view but won't suffer from glare.

Along with sunlight, good ventilation is important in a sick room. Make sure the patient is not subjected to drafts, but do try to have the air fresh and circulating. In the summer, an electric fan may help, but don't aim it right at the care-receiver.

Temperature and humidity are other things to consider. The room should be comfortably warm, and remember that sick and elderly peo often feel the cold more than others. The room temperature should be raised during bathing and treatment times. As for humidity, try to keep a sufficient amount of moisture in the room, especially during a dry Alberta winter. An elect humidifier, properly maintained, is a good idea.

Don't forget to keep the bedroom clean. Vacuum and dust it regularly, and keep free from the unpleasant odors that can sometime result from illness. Open a window to let in fresh air as often as possible without chilling the patient.

When I was in hospital to have my appendix out, I was surprised at how often they cleaned it. Every day people were there sweeping, dusting, and polishing; and whenever a patient left, not only did they change the sheets, as I'd expect, but they washed down the whole bed—all that hardware hospital beds have and everything.

That's right. The value of cleanliness can't be overstressed when it comes to dealing with sickness.

3. a. Analyse the rooms in your home. Which one could you best adapt for home care?

   b. Sketch a floorplan of the room you chose in question a. showing how the furniture could be placed. Think about the suggestions you've just been reading as you do this.

Compare your answers with those in the Appendix, Section 2: Activity 4.

Specialized Equipment

The needs of patients vary according to factors such as their ages, illnesses or injuries, and abilities. Sometimes special equipment may be needed to care for someone at home. This equipment can be bought, rented, or borrowed. Sometimes caregivers can improvise or adapt articles already in the home. Following are examples of commonly used home-care equipment.

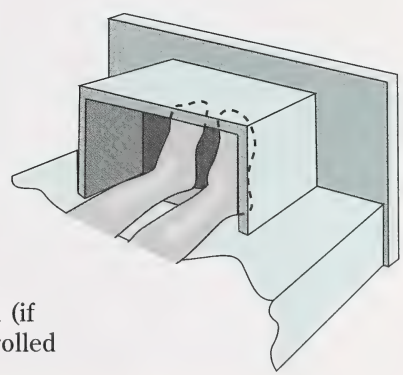
Equipment for the Bedroom

- A bed table or tray should be high enough to fit over the knees of the patient but low enough to work on. It must provide a comfortable surface that's easy to clean for eating, writing, playing cards, doing puzzles, and enjoying other recreational activities.

- A back rest provides support and comfort when a patient sits up in bed. A back rest may consist of several pillows, a triangular bolster, perhaps cut out of a piece of foam, a canvas or plastic backrest such as those used at the beach, or a form made of wood.

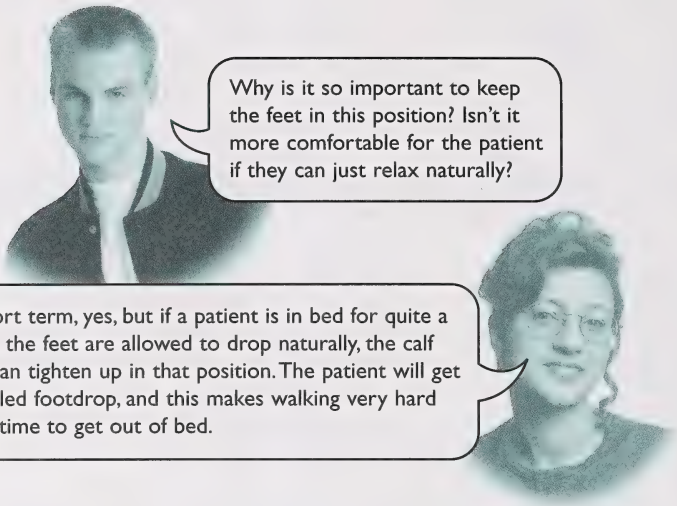
ed cradle: *a vice used to event the ight of the dclothes from sting on some rt of the body*

- A **bed cradle** is a simple device used to protect sensitive parts of the body from the weight and additonal pressure of blankets and quilts. This can be helpful, for instance, for fractured limbs and burns. A bed cradle can also help to promote air circulation to parts of the body under the bedding. A bed cradle can be made out of a light wooden box. Alternatively, you can elevate the bedding by placing it over the raised end of the bed (if it's high enough) or by placing pillows or rolled blankets under the covers.



otboard: *a dded device ed to keep a l-patient's feet perly sitioned*

- A **footboard** is used to maintain the proper position of the patient's feet (at right angles to the legs). It may be a hard pillow braced against the bedboard or made from a cardboard carton padded with a pillow. A footboard should be at least 5 cm higher than the patient's feet, and should always be padded.



bed blocks: *blocks used to raise a bed to make it easier for a patient to get in and out*

- **Bed blocks** are simple devices used to raise the height of an ordinary bed. Many care-receivers find it difficult to get in and out of a bed sitting at a normal height, and raising the bed to 75 or 80 cm can help them a great deal. Most bed blocks are simply wooden blocks with hollow tops into which the four legs of the bed are inserted.

- **A pull-up device** is used to help a patient sit up in bed. Earlier, you read about the "trapeze" that can be fitted to hospital beds. Versions of these can be set up in normal beds. A simpler type of device consists of a strong rope knotted to the foot of the bed, giving something for the patient to grasp and pull up on.

pressure pads: *soft items like pillows used to prevent irritation to the skin in places where pressure sores are likely to develop*

- **Pressure pads** are simply soft items like pillows, cushions, pieces of foam, and sheepskins that can be used to prevent irritation to the skin in spots like the elbows, heels, and the bottom of the spine. You encountered these before when reading about bed sores.

hip roll: *a rolled-up sheet or blanket placed tightly beside a bed patient to keep the body properly aligned*

- A **hip roll** is often needed by patients who are confined to bed on a long-term basis. It's used to prevent the hips from turning outwards to one side. A hip roll can be made by folding a sheet or blanket in half lengthwise and then rolling it up tightly. The roll should be placed along the patient's side from the waist to the knee so that the patient leans against it. This helps keep the body in good alignment.

hand roll: *a soft ball or some substitute with which a patient can exercise the hand muscles*

- A **hand roll** is used to keep a care-receiver's thumb in the correct position and to prevent fingers from contracting in a claw-like fashion from lack of use. A hand roll can be a soft rubber ball, a sponge, or a rolled-up face cloth. The patient exercises with the hand roll by squeezing and manipulating it.

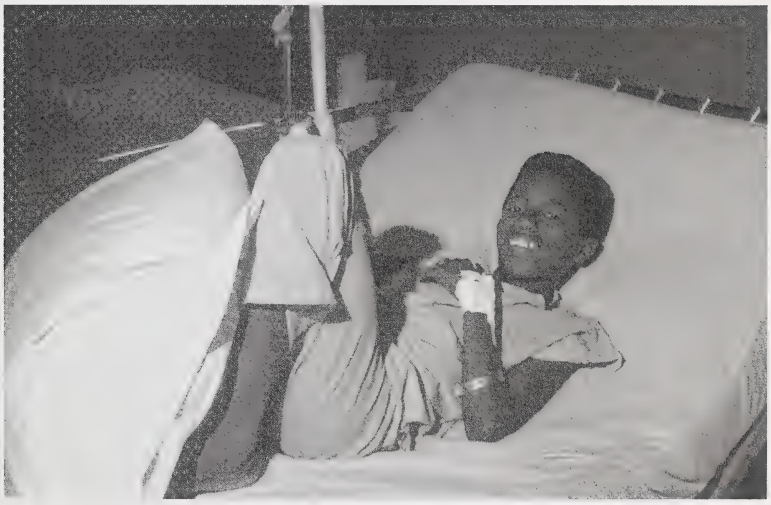
- **Plastic bedpans and urinals** are available for patients who are unable to get out of bed and get to a toilet.
- **Washable or disposable pads** are used to protect bedding when a patient is **incontinent** or has a discharging wound.
- A **bedside commode** is a portable toilet that's simply a chair with a seat that lifts up to reveal a toilet seat and a receptacle. Patients who can't walk to the bathroom, even with assistance, can make use of a commode.

incontinent: *unable to control the bladder and/or bowels*

bedside commode: *a portable toilet*

If a patient needs long-term care in the home, one option for a caregiver is to buy or rent a hospital bed. Hospital beds can be raised and lowered, and the foot and head can be adjusted so the patient can sit or recline comfortably. Handrails and pull-up devices can easily be attached to these beds to make movement easier. This may be more convenient than trying to adapt a regular bed.

Of course, depending on a care-receiver's conditions, many more devices may be required. A child, for example, may have different needs from an adult. But the preceding list should give you an idea of equipment that is available.



Equipment for the Bathroom

So far you've been looking principally at the bedroom, where many home-care patients spend most of their time, but other parts of the home may also have to be adapted to the needs of a care-receiver. The most important of these is the bathroom. The changes that will have to be made to the bathroom will depend on the needs of the patient, but here are several commonly used devices and adaptations:

- Support bars (or *grab bars*) can be installed in the shower, beside the bathtub, and beside the toilet. These sturdy metal rails, securely attached to the wall, give a patient something to hang onto while standing or when sitting down or getting up.
- Non-skid surfaces can be added to the bottom of the bathtub or the floor of the shower to reduce the risk of slipping when the surfaces are wet.
- A bench, normally made of plastic and stainless steel, can be fitted into the bathtub, thereby allowing the patient to get into the tub in a sitting position and remain seated, if necessary, while bathing.
- A fixed-shower head can be replaced by one with a flexible hose, allowing a seated patient to shower conveniently.
- A raised toilet seat can be installed over the toilet to help a care-receiver stand up and sit down.
- Lever-operated taps can be installed on the sink, the shower, or bathtub to make it easier for a care-receiver with restricted hand capabilities to operate them.
- A temperature-control device can be placed on the hot-water tap to prevent the danger of scalding.

4. Name the device that would help in each of the following situations:

   a. A patient with a fractured hip has trouble standing up from her bed.

   b. A patient is developing pressure sores on his elbows.

   c. A patient is developing footdrop from lying on his back for many days.

   d. A patient is incontinent.

   e. A patient can't grasp and turn a tap with a normal grip.

   f. A patient finds the constant weight of blankets uncomfortable for her injured foot.

   g. A patient who can't roll over finds he can sleep more comfortably on his back if his back and head are raised.

   h. A patient in bed for quite some time may have difficulty keeping her body in alignment.

Compare your answers with those in the Appendix, Section 2: Activity 4.

Adapting the Rest of the Home

The bedroom and the bathroom are normally the most important rooms to be adapted to the needs of a care receiver. However, other changes often have to be made in the home as well—especially if the patient is mobile enough to move from room to room—perhaps in a wheelchair or aided by crutches or a walker. In a home where a care-receiver has limited mobility, two factors are of prime importance:

- safety
- accessibility

Safety Issues

Falls are the most common type of accident in the home for people of all ages, and this is especially true of home-care patients. The most frequent causes of falls are

- the presence of scatter rugs without non-skid rubberized backing
- slippery floors
- clutter on the floor
- furniture on castors (which can easily move when leaned upon)
- items kept high and out of reach (resulting in people falling while trying to get access to them)
- stairs, tubs, and shower stalls without a non-skid surface

5. a. Examine your home, looking for areas where a person, especially an elder or infirm (weak or feeble) individual with limited mobility, could fall.

   b. For each area you identified, suggest how the danger might be eliminated or minimized.

6. Friends of yours have learned that their great-grandfather will be staying with them as a home-care patient. He gets around a bit indoors with a walker but is very unsteady. Knowing that you are taking a Community Health course in Home Care, your friends have asked you for advice on how to make their hom safer for their new guest. What suggestions would you make?

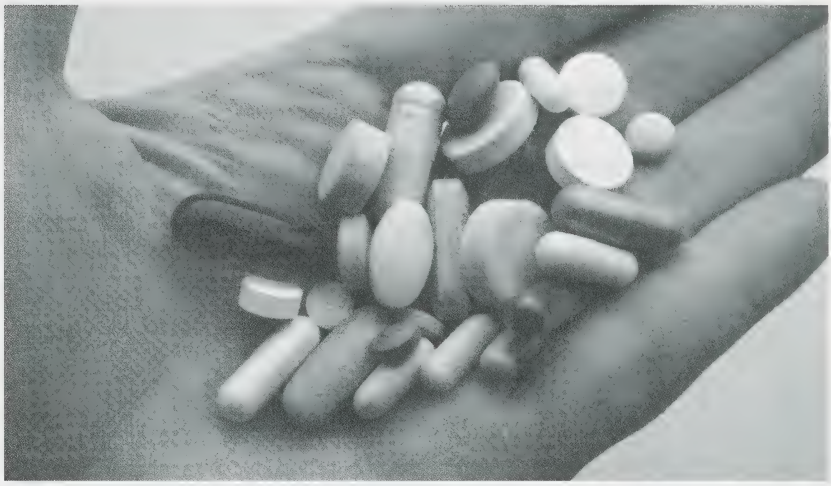
Compare your answers with those in the Appendix, Section 2: Activity 4.

While falls are the chief problem in the area of safety when it comes to home car they are by no means the only ones. Here are a few more things to bear in mind:

- Burns from hot water or food are a danger to a partially mobile care-receive You've already learned that hot-water taps in sinks, bathtubs, and showers can be adjusted with a safety device that prevents turning to the highest possible setting. If the care-receiver has access to the kitchen, be sure to keep pot handles turned toward the back of the stove.

- If a smoker, your care-receiver, like anyone else, should never be allowed t smoke in bed. If handling matches or cigarettes is a problem, smoking should be permitted only under supervision. Controlling the smoking habit of an adult who has enjoyed many years of independence can present problems, especially when the person is a parent or older relative. Howeve safety must come first.

- If your care-receiver has to take several different medications daily, keeping these straight can be a problem. Normally, the nurse in charge of the home-care situation will entrust the primary caregiver with the job of administering medications and train that person how and when to administer them. It's important, especially if the patient is elderly or of unsound mind, to keep these medications somewhere where they won't accidentally be consumed.



7. Can you think of other safety concerns in a home with a partially mobile home-care patient? See if you can suggest **two or three**.

Compare your answer with the one in the Appendix, Section 2: Activity 4.

Accessibility

Related to the issue of safety is that of accessibility. If you make the effort to reduce the falling hazards in a home, you're already making areas of the home more accessible to the care-receiver. A room free of scatter rugs or clutter on the floor is automatically more accessible to a patient using crutches, a walker, a wheelchair, or a cane. A bathroom equipped with non-skid surfaces and equipment as described earlier in this activity is definitely more accessible to a care-receiver who has difficulty getting up and down or manipulating objects. Other steps also may have to be taken to make a home more accessible for home-care patients.

You mean, like a wheelchair ramp leading up to the door—or even just sturdy railings on the stairs?

Exactly. Other things you might consider doing would be widening doors for wheelchair accessibility or installing doorknobs with levers or paddles. The chart that follows contains quite a few fairly simple ideas, though they won't all be appropriate in every situation. Of course, there are many, more elaborate, adaptations that you might make, including expensive ones like electric elevators and mechanical harnesses for moving patients. You can also get devices installed in your vehicle for getting patients in and out easily.

WAYS TO MAKE A HOME SAFE AND ACCESSIBLE FOR A HOME-CARE PATIENT

Stairs	◦ ramps for wheelchairs ◦ strong railings, preferably on both sides ◦ lighting at top and bottom ◦ non-slip treads
Bathrooms	◦ grab bars ◦ accessible sink and toilet ◦ shower/tub seat; tap levers or paddles ◦ water-temperature controls
Floors	◦ non-slip surfaces ◦ no clutter: no scatter rugs or mats
Doors	◦ wider doorways ◦ levers or paddles rather than knobs
Entrance	◦ doorbell-awareness lights ◦ door intercom
Kitchen	◦ lower counters and shelves ◦ under-counter lights
General	◦ night lights ◦ general improvement in lighting throughout house ◦ on and off touch lighting, oversized light switches for visually impaired persons ◦ telephone-awareness lights/jumbo-button phones/phones for hearing-impaired persons

Teamwork

8. Can you add to this chart? If possible, get together with a friend and brainstorm ideas for making a home a safer place. Focus primarily on home-care situations, but feel free to add any general safety precautions you can think of.

Compare your answers with those in the Appendix, Section 2, Activity 4.

In this activity, you have thought about ways in which a home can be made accessible, safe, and suitable for setting up a home-care situation. Of course, the needs of every individual patient will be different, but you should have a general idea of some basic adaptations you might have to make. Bear in mind, too, that for some patients rather expensive equipment may be required if an acceptable quality of life is to be maintained. For the most part though, the things needed for a care-receiver are relatively cheap and accessible. Some may be supplied free of charge through your local health unit, while others can be bought or rented. A few, as you've seen, can be contrived with common household items and a bit of ingenuity as long as safety is the key consideration.

FOLLOW-UP ACTIVITIES

If you had difficulty understanding the concepts in the activities, it's recommended that you do the Extra Help. If you have a clear understanding of the concepts, it's recommended that you do the Enrichment.

Extra Help

One of the things you looked at in this section was the use of heat and cold treatments in caring for patients. It's important for nurses, nursing assistants, personal-support aides, and home-care providers to know when these treatments are appropriate. If uncertain, a caregiver in the home should consult a professional, such as a nurse.

1. Bearing the preceding discussion in mind, tell whether a heat or a cold application would be appropriate in each of the following situations, or whether neither one should be used.

   a. A small wound is bleeding.

   b. A patient bruises his elbow and, though no serious damage has been done, it's paining him.

   c. A patient's muscles are tense and she's experiencing tension headaches.

d. There's some swelling in a patient's ankle caused by a mild sprain.

e. A wound won't seem to drain as well as you'd like it to.

f. A patient is suffering from poor circulation in the feet.

g. A patient has a slight fever.

h. A patient is suffering from mysterious sharp pains in his abdomen.

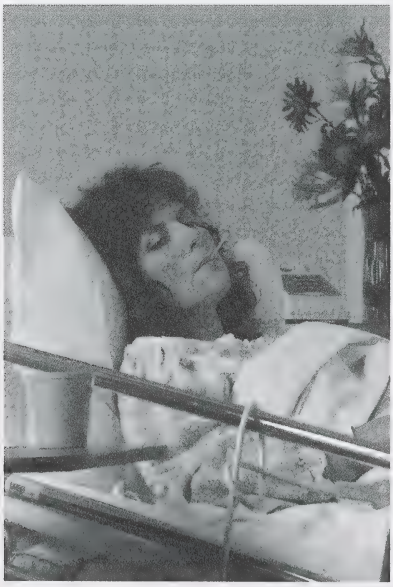
2. Taking a pulse rate can be an important part of the monitoring of a home-care patient's health. Rewrite each of the steps that follow to correct any errors.

a. Have the care-receiver get up and move around to get a good, strong pulse.

b. Place your thumb or forefinger on the patient's wrist just above the base of the thumb.

c. Squeeze hard to make sure you feel the pulse clearly.

d. With an eye on your watch, count the patient's pulse beats for a full 25 seconds.



Taking a patient's temperature is another important aspect of providing home care. While today many health-care professionals use modern, digital thermometers that give quick readings when placed in a patient's ea or on the skin, it's important for caregivers to be familiar with conventional glass thermometers.

3. Indicate whether each of the following statements is true or false. Correct any false statements.

   a. A patient shouldn't smoke or eat or drink anything hot for at least 20 minutes before temperature taking.

   b. Before taking a person's temperature using a glass thermometer, the liquid in the fluid line should be below the arrow that indicates normal body temperature.

   c. A person's temperature can be taken under the arm if necessary, but it's not as accurate as the oral method.

   d. It can take up to eight minutes to get a truly accurate temperature reading with a glass thermometer.

   e. When a patient has nasal congestion, the patient's mouth may be left open while having a temperature taken as long as the thermometer is under the tongue.

4. Shifting a patient up toward the head of the bed can take some practice. Without looking back, if possible, list the steps involved in this process.

5. Again without looking back, identify the item(s) a home-care provider should use in each of the following situations:

   a. A patient is showing early signs of developing pressure sores.

   b. A patient confined to a bed for quite a lengthy stay is in danger of developing footdrop: a condition whereby the patient experiences weak muscles and joints in the foot and lower leg.

   c. A bed patient tends to lie so that one hip is constantly turned outward from the body.

   d. A patient's hand muscles are tightening from lack of use, pulling the fingers inward like a claw.

   e. A patient can get out of bed with help and stand up for a few seconds but can't walk to the bathroom.

   f. A patient can't manipulate the taps in the bathroom sink.

   g. A patient can stand to shower but is in danger of slipping on the wet tiles.

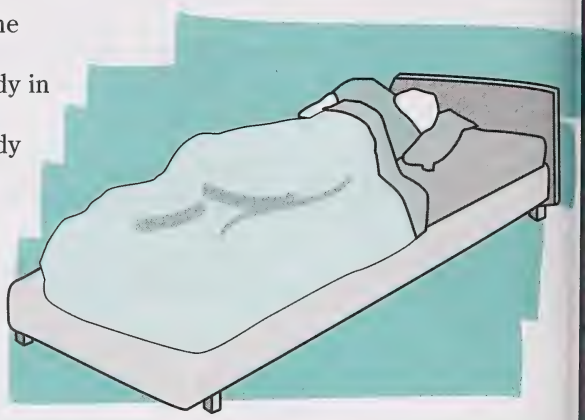
6. Providing a care-receiver with a proper, nutritious diet is an important part of being a caregiver. Imagine that you were looking after a patient on a "soft diet." Describe the type of meals you would prepare.

Compare your answers with those in the Appendix, Section 2: Extra Help.

Enrichment

Do **one or more** of the following:

1. Do you make your bed in the morning? Can you imagine making a bed with somebody in it? Now can you imagine making a bed with somebody in it who is unable to assist you by shifting around as required? The fact is, though, that home-care providers are frequently required to make a bed with a care-receiver in it; so it's a skill anyone involved in home care should acquire. The steps that follow will take you through the process, which involves unmaking and remaking one side of the bed at a time:



   - Wash your hands.
   - Make sure the bedroom is nice and warm.
   - Assemble the clean bedding that you'll need. The bottom sheet should be folded lengthwise.
   - Walk around the bed and loosen all the sheets.
   - Remove the bedspread, blankets, extra pillows, and so on.
   - Leave the care-receiver covered with the top sheet while you unmake the bottom one.
   - Roll the patient onto his or her side (as you've been taught) on one side of the bed and pull the patient toward you.
   - Move to the other side of the bed (facing the patient's back) and loosen the bottom sheet, folding it toward the centre of the bed.
   - Smooth out the mattress cover that lies under the sheet.
   - Lay the clean bottom sheet, folded lengthwise, on the bed with the fold toward the centre.
   - Tuck the loose edge of the bottom sheet neatly under the mattress.

- Spread the sheet, as taut as you can get it, over to where the patient is lying.
- Carefully roll the patient toward you and onto the clean sheet.
- Go around to the other side of the bed and remove the old bottom sheet completely.
- Smooth the mattress cover on this side of the bed.
- Unfold the other side of the clean sheet toward you and neatly tuck it in.
- Tuck the bottom sheet neatly in at the ends of the bed.
- Roll the patient back into a comfortable position.
- Place a clean top sheet over the old one covering the patient.
- Have the patient hold the clean top sheet, if possible, while you slip the old one out from the bottom of the bed.
- Allow room for the patient's feet, and tuck in the top sheet at the bottom of the bed.
- Put back all the blankets and pillows along with the bedspread.
- Make sure your patient is comfortable.
- Wash your hands.

If you can recruit a friend or family member to be the patient, practise this bed-making method. See how taut you can get the sheets with someone lying in the bed.

2. Sometimes a caregiver is called upon to assist or give a care-receiver a bath in bed. Read the description that follows; then, imagining that you had to teach someone how to administer a bed bath, list the steps involved.

Karen broke her leg badly while snowboarding and is confined to bed for at least three weeks. She can't get her cast wet, so she must carefully bathe herself in bed.

Karen's mother helps her. She begins by making sure the room is warm (between 20° and 24°C), and assembling all the necessary equipment. She covers the cast with plastic to prevent it from getting wet. Then she removes the top bedding, leaving a sheet to cover Karen and a pillow to support her head and shoulders. Next, she helps raise her daughter into a sitting position and assists her in removing her nightgown. She places a towel under Karen's head and shoulders and stands by to hand her a soapy (but not dripping) washcloth as needed.

Once she's set up, Karen can wash her face first and gradually work her way downward. She can get her mother to rinse, soap, and wring out her washcloth as often as necessary. Then they'll repeat the process as Karen rinses herself with clear water and dries herself with a clean towel. This way, Karen can wash, rinse, and dry one part of her body at a time. To keep warm, Karen may want to immediately cover each area after it's been washed.

When Karen has washed as much as she can, her mother will help her turn; she can then wash her daughter's back. It might be a good idea to give Karen a back rub using some lotion at this point as well. Next, her mother can wash her free foot and leg, since Karen would have difficulty reaching them. While Karen completes her bath, her mother should encourage her to be careful with any area where folds in the skin can cause chafing if left damp: areas like the armpits and groin. In these areas, Karen should take special care to wash, rinse, and dry herself thoroughly. After Karen washes and dries her groin area last, her mother can take the washcloth and towel and make sure they go directly into the laundry.

When the bath is over, Karen's mother can help her put on clean clothes. She may also help her cut and file her nails and comb her hair at this point. If Karen and her mother have been careful, the sheets shouldn't even be damp.

3. The Internet provides a wealth of information for caregivers. One Canadian site you were directed to in the Enrichment for Section 1 was

   - **http://www.caregiver.on.ca/**

   This is the website operated by Caregiver Network Inc., a Canadian resource centre created to help caregivers of the elderly and ill. If you explore this site, you should come up with more information about providing safe and comfortable home care as well as some of the issues facing caregivers.

   If you'd like to learn more about home-care issues on the web, go to the following address:

   - **http://ca.yahoo.com/Health/Long_Term_Care/Caregiving/**

   This takes you to a Yahoo directory of many Internet sites devoted to the issue of caregiving. These websites should help you learn a good deal more about the issues involved in caregiving.

   If this isn't enough information for you, use the search words 'caregiving' to search for other home-care sites.

Compare your answers with those in the Appendix, Section 2: Enrichment.

CONCLUSION

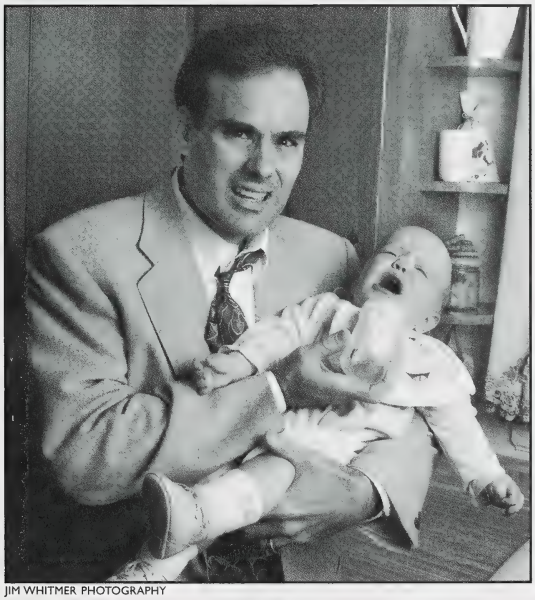
In Section 2, you moved away from the focus on general home-care issues that characterized Section 1, and you got into some of the hands-on processes and procedures that a home-care provider must learn. You now know something about maintaining cleanliness and dealing with sterile dressings, using heat and cold applications, and checking for vital signs. You also have a grounding in some of th routine aspects of transferring patients in and out of bed and shifting them within the bed. As well, you now are able to provide wholesome, nutritious, and appealing meals for care-receivers, and you've learned how to adapt a home environment to the needs of home care.

Section 2 has introduced you to the challenge of maintaining good skin care when a patient is in bed for an extended time. In fact, caring for the skin is an especially important job for home-care specialists. For this reason, the next section in this course is taking a deeper look at the needs of skin care for home-care receivers.

ASSIGNMENT

Turn to Assignment Booklet A and do the assignment for Section 2.

The Skin—The Body's Largest Organ



JIM WHITMER PHOTOGRAPHY

MR. Thibodeau is trying to comfort his young daughter, Danielle, who doesn't seem well. He discovers that her upper torso is covered with a rash consisting of small red spots. There's no fever. Knowing that Danielle has had a measles vaccination, Mr. Thibodeau can't figure out what's going on. Is it serious, or isn't it?

Do you have any suggestions for Mr. Thibodeau? Do you have any ideas about what the rash might be? Did you know that the skin has been described as the body's "cutaneous envelope," the integument. Like an envelope, the skin both contains you and protects you. A rash is the skin's reaction to something in the environment or a condition within your body.

In this section, you'll be introduced to the human *integumentary system*—the skin and its appendages. When you've finished the section, you should be able to explain the basics of the anatomy, physiology, pathology, and care of the skin. You may also be able to help Mr. Thibodeau look after Danielle's rash.

SECTION 3

ACTIVITY 1

Understanding the Skin

Did you notice the title of this section? Were you aware that the skin is the body's largest organ? Did you even think of the skin as being an organ? The fact is that 15 percent of the average adult's weight is skin; if spread out, it would cover a surface area of nearly two square metres. The importance of this complex organ is made apparent if you look at the mortality (death) rate of people who have been badly burned. When the skin is badly damaged, a person's life is seriously threatened.

Before we go any farther, I have a question. This is a course on home care, isn't it? How come we're doing a whole section on the skin?

Good question. If you look at the courses offered in Community Health, you'll find a number devoted specifically to particular systems of the body, such as the musculoskeletal system and the circulatory system. The **integumentary system** doesn't get an entire course devoted to it, but it fits in logically with a study of home care. That's because maintaining good skin health is one of the chief concerns of most home-care providers—something you saw briefly in the discussion on pressure sores. Anyone who wants to work or be involved in home care has to have a good grounding in the human integumentary system—in other words, the skin.

integumentary system: *the organ of the body comprised of the skin and its appendages (hair, nails, sweat glands, and oil glands)*

capillaries: *tiny blood vessels connecting arteries and veins*

pigmentation: *colour*

The skin is really quite an amazing organ. For one thing, it's remarkably elastic, and can stretch to accommodate such things as muscle movements or the rapid abdominal growth that characterizes pregnancy. For another thing, the skin contains a vast number of tiny blood vessels called **capillaries**. One square centimeter of skin may contain 1.5 meters of capillaries. It's the blood flowing through these vessels that can give the skin a rosy colour, as when you blush (though this is also affected by the degree of **pigmentation** present in the skin itself). When the capillaries dilate (or widen), the colour deepens. The capillaries will constrict (or become narrow) if you're cold or afraid.

1. a. Explain why the skin of a lightly pigmented person can become bright pink if the person exercises strenuously or becomes very warm.

   b. (i.) What happens to a light-skinned person's skin colour when that person becomes very cold?

   (ii.) Suggest a reason for this.

Compare your answers with those in the Appendix, Section 3: Activity 1.

The skin varies in the texture and thickness according to where it's found on the body. Skin is thinnest on the eyelids. It will also be thinner in areas normally covered by clothing. Areas exposed to air and which receive considerable wear, such as on the hands, have skin that is much thicker than that found on the arms or back.

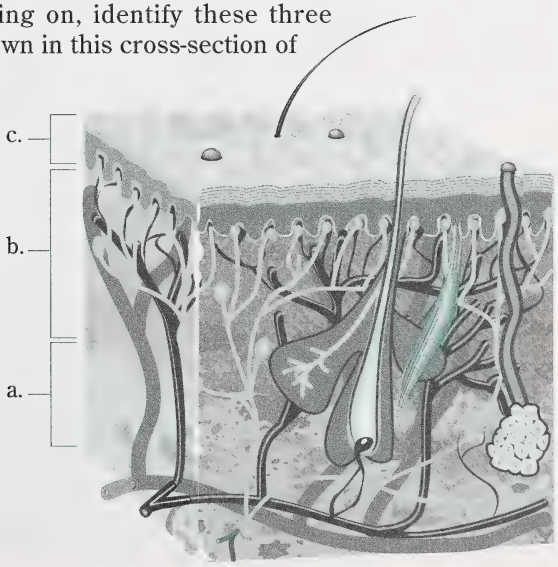
Were you aware that the outer surface of your skin is being constantly worn away? In fact, this process can create a new layer of outer skin every three to four weeks. Much of the content of household dust is, believe it or not, made up of tiny particles of dead skin.

The Layers of the Skin

Our skin is divided into three distinct layers. They are

- the epidermis
- the dermis, or corium
- the subcutaneous tissue

2. Before reading on, identify these three layers as shown in this cross-section of human skin.



Compare your answer with the one in the Appendix, Section 3: Activity 1.

epidermis: *the outer layer of skin*

The outer layer of skin is called the **epidermis**. This layer can be about as thin as a piece of paper or as thick as a millimeter; despite it's thinness, the epidermis contains five distinct cell layers, or strata:

- stratum corneum (flat, dead cell layer)
- stratum lucidum (clear cell layer)
- stratum granulosum (granular cell layer)
- stratum spinosum (prickly cell layer, or spinous cell layer)
- stratum germinativum (basal cell layer)

stratum corneum: *the outer layer of the epidermis*

keratin: *a protein that hardens skin cells when they die*

The **stratum corneum** is the outer layer of the epidermis. It's actually a layer of flat, dead cells. It has no blood vessels.When the skin cells die, they undergo a chemical process that changes them from soft, easily damaged cells into hard, tough, cornified (callous) ones. A protein called **keratin** hardens the cells and makes them waterproof. This process is called keratinization.

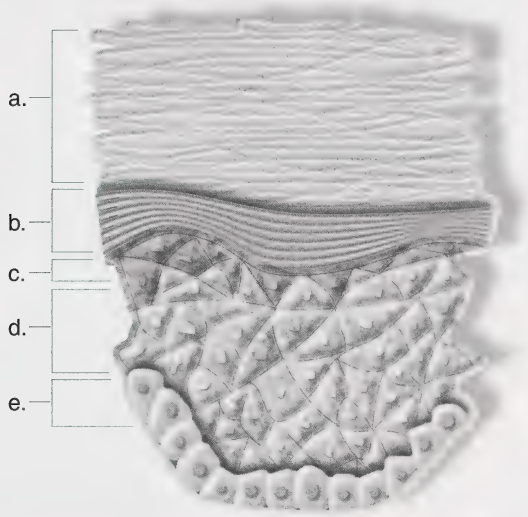
The other layers of the epidermis all have a protective function to play. The bottom layer of the epidermis, the stratum germinativum, constantly produces new cells to replace the epidermal cells that have died and been lost. New cells push up from this layer and are eventually shed from the surface. Over a lifetime, a person can lose over 20 kilograms this way.

melanin: *the pigment in the skin which (along with blood vessels) gives it its colour*

The basal layer of the epidermis, the stratum germinativum, also produces **melanin,** the pigment that colours the skin. Melanin is stimulated by exposure to ultraviolet light, which it receives primarily from the sun. Large doses of sunlight result in the production of this pigment, which causes the skin to tan. During the tanning process, melanin moves up into the stratum corneum to protect the skin from the burning rays. Without protection, the hot rays of sunlight can destroy several layers of epidermal cells, causing a painful burn and blisters.

3. These days, with the thinning of the protective ozone layer of the atmosphere, we're constantly being reminded to protect ourselves from UV radiation. Suggest **three** ways in which sunburn, and resulting damage to the epidermal layer of the skin, can be prevented.

4. This diagram shows the skin's epidermis; the letters indicate the five epidermal layers. See if you can label them without looking back.



Compare your answers with those in the Appendix, Section 3: Activity 1.

ermis: *the layer skin between e epidermis and e subcutaneous ssue*

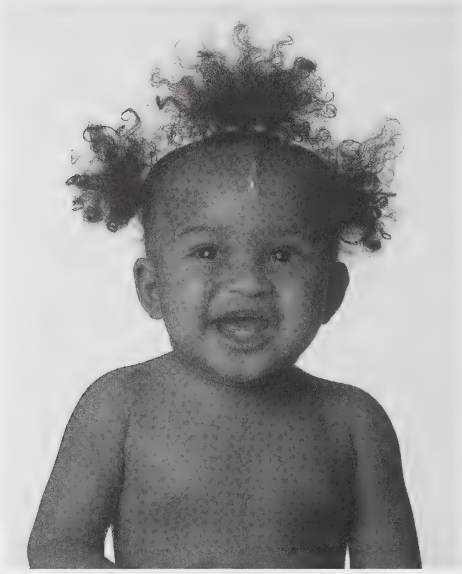
Below the epidermis, lies the **dermis.** A wavelike layer is formed by many tiny cones and ridges where these two layers meet. The resulting patterns show through to the surface of the skin on the hands and feet. Some of them become what we know as fingerprints and footprints—a means of identification because they are unique for each person.

The dermis is 20 to 40 times thicker than the epidermis: a thick, active layer made of tough, fibrous connective tissue. This layer of skin provides a flexible support structure; it contains blood and lymph vessels, nerves, sweat glands, and oil glands. Blood vessels in the dermis provide nutritients to the skin, help maintain a constant body temperature, and provide circulation of white blood cells that help defend against infection and foreign substances.

bcutaneous ssue: *the layer skin made up fatty tissue ng below the rmis*

The layer of fat cells that lies beneath the dermis and acts as an insulator and shock absorber is called the **subcutaneous tissue.** This tissue also stores energy in the form of calories as a reserve nutritional source. The thickness of this layer varies in different parts of the body; it tends to be thickest at the waist and practically nonexistent in the eyelids.

Appendages of the Skin



Along with the three basic layers of the skin, this organ contains a number of structures that are normally classified as *appendages*. These include

- sweat and oil glands
- hair
- nails

The skin contains many different kinds of glands. One kind is called **sebaceous glands.** They produce the oily substance called **sebum** which keeps the skin soft and helps to waterproof its surface. Sebum also keeps hair from becoming dry and brittle. Underactive sebaceous glands cause the skin and hair to be dry; overactive glands result in oily skin and hair.

▼

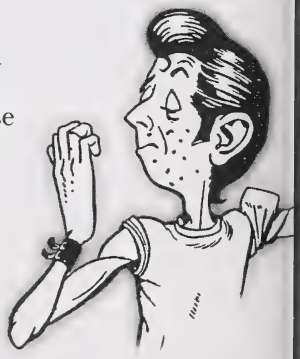
sebaceous glands: *glands in the skin that produce the oily substance called sebum*

sebum: *the oily substance produced by the sebaceous glands*

▲

The amount of sebum secreted by the sebaceous glands depends on age, race, climate, and individual differences. Some people have small, underdeveloped sebaceous glands while others have numerous large ones. Infants produce little or no sebum but during adolescence, production increases significantly. After the age of fifty, sebum production generally decreases again. Often people with dark skin have larger and more numerous sebaceous glands than others, and those living in warm climates generally secrete more sebum than those in cooler parts of the world.

When the secretions of the sebaceous glands come into contact with oxygen in the air, they can become black in colour. This results in what are commonly known as *blackheads*. If the glands become infected, they can cause pimples or acne. Because sebaceous glands are most abundant on the scalp, face, upper back, and chest this is where infections occur most often.



5. a. How would you rate your own sebaceous glands? Is your hair oily or dry? Do you have to use hand lotion frequently?

   b. Does your skin seem more oily in different seasons of the year?

Compare your answers with those in the Appendix, Section 3:Activity 1.

eccrine glands: *sweat glands that produce a watery, cooling secretion*

Along with sebaceous glands, the skin also contains two types of sudoriferous glands (or sweat glands). The most common are **eccrine glands**. They're located in the dermis and occur in most areas of the body, though they're most common under the arms, on the palms of the hand, on the soles of the feet, and on the forehead. There are two to three million eccrine glands in an adult's skin.

Eccrine glands secrete a cooling watery substance that moves through tiny ducts to the surface of the skin. These glands are stimulated to do this by nerves that activate when the body temperature rises or when a person is in a state of nervous tension. The secretion, once it appears on the skin's surface, evaporates, thereby cooling the person.

apocrine glands: *sweat glands responsible for body odour*

The other type of sweat glands are called **apocrine glands**. These glands are associated with body odour and occur most noticeably under the arms and in the genital area. They enlarge and become active at puberty. Apocrine sweat is a fluid containing water, salt, uric acid, lactic acid, proteins, and carbohydrates. Body odour is produced when bacteria begin to decompose apocrine sweat.

hair follicle: *a small, hollow structure from which a hair grows*

Another appendage of the skin is hair. **Hair follicles** are distributed over the entire body except for the palms of the hands and the soles of the feet. In fact, humans have approximately the same number of hair follicles as chimpanzees. However, over most of the body the hairs produced by these follicles are small and transparent. Hair follicles are sacs extending from the stratum corneum of the epidermis down into the dermis. At the base of each follicle is a bulb where the hair shafts begin to grow. The hair itself, growing out of the follicle, is simply a strand of tightly packed keratinized cells.

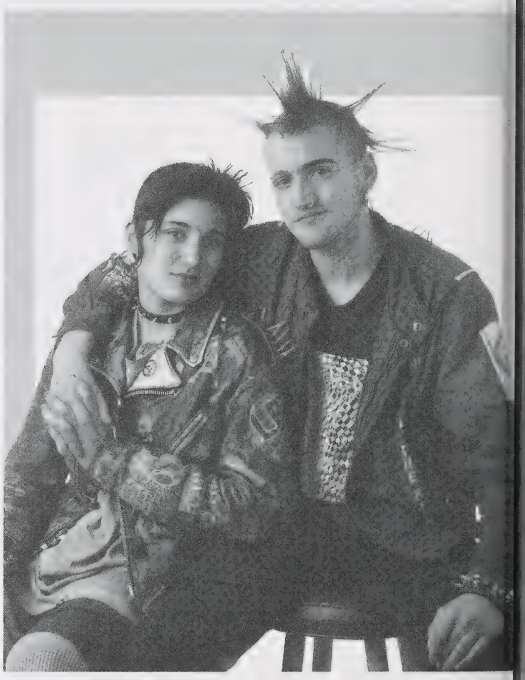
vellus hair: *the fine, soft, wispy hair that covers most of the body*

terminal hairs: *the relatively coarse hair that grows in specific areas of the body*

There are two types of hair shaft. **Vellus hair** is fine, soft, wispy hair that's usually barely noticeable. **Terminal hairs** are thicker, longer, and darker. On some body areas, terminal hairs are hormone-dependent and don't appear until puberty. Hair growth in each follicle is cyclical; there's an active growing phase and a resting phase. A follicle grows one hair for two to six years, and then growth stops. At this point, the follicle goes into its resting phase for about four months. Then the hair is shed and the cycle begins again. An average adult sheds about 40 to 100 hairs each day from all over the body!

Human hair grows at a rate of about 0.3 millimeters each day (or about 1 centimeter per month). The length of a hair depends on the length of time the growing part of its cycle lasts. That's why some people can grow scalp hair down to their waists or lower while other people have trouble getting their hair to reach to their shoulders. The former simply have longer growing cycles.

A hair-erector muscle (arrector pili muscle) is connected to each hair follicle. When this muscle contracts in response to cold or fear, it pulls the follicles upright. This produces the bumpy appearance of skin that people call *goose bumps, goose pimples*, or *goose flesh.* When people say that they *felt the hair stand up on the backs of their necks*, to some degree this is actually happening. It's the same phenomenon that causes a threatened cat to suddenly appear larger as its hair bristles out.



A third skin appendage consists of toenails and fingernails. Nails are hard structures produced by the epidermis. Like hair and (in some animals) horn, nails are made of the protein keratin. Nails grow from the *nailbed* in the basal and spiny layers of the epidermis (stratum germinatavum and stratum spinosum). The nailbed constantly produces cells, which results in the elongation of the nail. Nails serve to protect the fingers and toes. They also aid in grasping and picking up small objects.

6. Identify the appendage indicated in each of the following:

   a. glands that produce an oily substance

   b. sweat glands that produce body odour

   c. heat regulators for the body

   d. an appendage that has a tiny arrector muscle attached

   e. an appendage made hard and durable by keratin

   f. a fine, wispy appendage covering most of the body

Compare your answers with those in the Appendix, Section 3: Activity 1.

The Functions of the Skin

The skin is really the first line of defence in preventing bacteria from entering body tissues. If the skin becomes cut or badly scraped, the bleeding will generally wash out most bacteria and then clot to close the wound. Then the skin will heal the wound by replacing the damaged cells around it.

The skin also protects the soft inner cells from wear and tear, and it keeps these tissues from drying out. The oil produced by glands in the skin make it nearly waterproof; little water passes out except through the sweat glands.

As you've seen, another function of the skin is to help regulate body temperature. In fact, about 87 percent of body heat is lost through the surface of the skin as sweat on the surface of the body evaporates, taking heat from the body in the process. This cools the body down. It's vital that the temperature of the body stay within very narrow limits of 37 degrees Celsius. Even a variation of half a degree Celsius can affect our sense of well-being. If the body gets too hot, blood vessels will dilate, the muscles will relax, and sweat glands will spring into action.

Of course, you don't want too much heat to escape through all the surface area offered by the skin. To prevent this from occurring, deposits of fat beneath the skin form an insulation barrier to reduce heat loss and help maintain a normal body temperature.Women generally have a higher percentage of fat cells than men do; so in severe conditions, women should be more resistant to cold than men.

Then how come in my family it's the women who always seem to be turning up the thermostat?

Because women also tend to have a slower metabolic rate than men; in other words, they turn calories into energy more slowly. That means that in the short haul women may feel colder than men; but over a prolonged exposure to cold conditions, they'll lose body heat and energy more slowly and can tolerate cold for a longer time than men can.

The skin contains many specialized nerve endings that can monitor conditions throughout the body and send impulses to the brain. These nerve endings will respond to such stimuli as touch, pressure, heat, cold, and pain. Pressure-sensitive sensors are deeper in the skin than touch sensors. There are more cold receptors than heat receptors because cold is a greater threat to body-temperature stability. The nerve endings sensitive to pain are found just below the epidermis and around hair follicles, which is why pulling out a hair hurts so much. The forehead has about 200 pain receptors per square centimeter, while the outside of the nose has only about 50. The earlobe contains even fewer.

7. Jan wants to pierce either her eyebrow or her nose. Which process would likely cause her less discomfort?

Compare your answer with the one in the Appendix, Section 3: Activity 1.

Another function of the skin is to shield the body from the harmful rays of the sun. Ultraviolet radiation from the sun is harmful to blood vessels and other tisues; skin exposed to too much ultraviolet light becomes pink and painful—what people speak of as *sunburn*. The skin's response to this assault is to produce protective melanin at a faster rate than normal; melanin is the pigment that causes a suntan. Unfortunately, this takes time, so while a tan does provide some protection from harmful rays of the sun, it also indicates that the skin has already been damaged. It's ironic that a look that people associate with health and fitness actually indicates skin damage.

But while the sun can harm the skin, people do require some exposure to sunlight. That's because vitamin D is produced when your skin is exposed to the sun, and it can't be produced by the body in any other way. You need vitamin D for many things—among them is the proper use of calcium to develop and maintain strong bones. You don't need much time in the sun to produce all the vitamin D you need. A sunscreen may prevent the synthesis of Vitamin D.

8. Some people in our society work hard at getting and keeping suntans. Untanned people are thought to look less healthy, fit, and attractive than those with that deeply bronzed look. Ironically, any tan at all is an indication of damaged skin. Steady tanning can bring about wrinkles, discoloration, and sagging, leathery-looking skin later in life. And once skin has been harmed this way, you can't change things with moisturizers and lotions.

   Do you have any friends who work hard on their suntans each summer? Do they ever visit tanning salons during the off season? If so, what advice would you give them?

Compare your answers with those in the Appendix, Section 3: Activity 1.

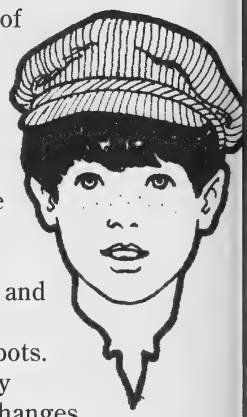
Common Skin Features

People's skin varies in many ways: colour, dryness or oiliness, the presence of freckles and moles, the tendency to blister or burn, and so on. Of course, everyone knows that people's fingerprints are all unique. With the possible exception of identical twins, the chances that someone will have just the same patterns of loops and whorls as someone else are estimated to be about 39 trillion to one!

Pigmentation, or colour, is perhaps the most obvious way in which people's skin varies. Pigmentation differences can simply involve differing degrees of shading, from the high pigmentation of a darker-skinned person to skin that has no pigment whatsoever—a condition called **albinism**. (People with albinism, called *albinos*, have pinkish skin, white hair, and pink eyes—the pink colour coming from blood vessels.) Other common features caused by pigmentation differences include

albinism: *a condition caused by a congenital failure of the skin to produce melanin, or pigment*

- freckles
- birthmarks
- moles
- liver spots



Freckles (or *lentigines*) are small, harmless spots or patches of pigmented skin. They often begin to appear at about age seven or eight. Children with red or blonde hair are more prone than others to develop freckles since freckles are the skin's attempt to protect the fair skin from the sun's ultraviolet rays. This is why the arms and face (especially the area across the nose) are likely to develop freckles; these are the surfaces most often exposed to the sun.

Moles, or *pigmented nevus cells*, can occur shortly after birth and continue forming on into early adulthood. The brown pigmentation of moles first appears as *macules* or coloured spots. Over time, a macule may become raised. Moles are extremely common, and most moles are harmless. However, if a mole changes colour or begins to grow or change shape, it should be reported to a **dermatologist**. This is because a potentially fatal form of skin cancer (malignant melanoma) can begin with an overabundance of pigmentation in a mole.

dermatologist: *a doctor specializing in conditions of the skin*

9. Take a few minutes to examine your own body for moles and try to remember what you notice. As you get older, you should do this regularly so that you'll be quick to spot any changes. Most people with moles never do have a problem, but with skin cancer rates on the rise due to the thinning of the Earth's ozone layer, it's wise to be careful. Look especially for these indicators:

    - a mole that appears after early adulthood (normally the process has stopped by this time)
    - a mole that is growing or changing shape
    - a mole with a variation in colour
    - a mole with an irregular shape or texture

Compare your answers with those in the Appendix, Section 3: Activity 1.

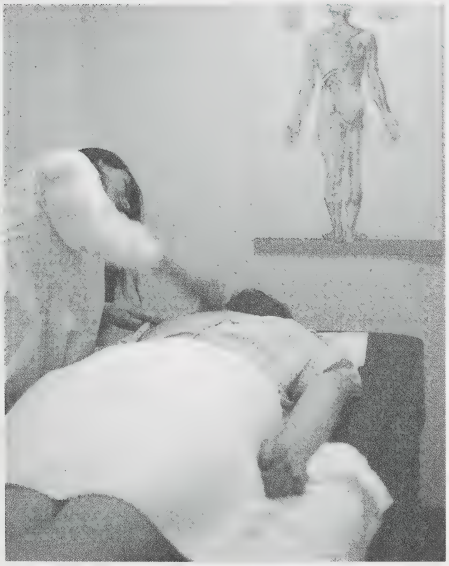
Birthmarks are caused by an unusual pattern of capillaries and heavily pigmented skin. Sometimes children are born with birthmarks that fade shortly after birth, but if they don't disappear soon, become permanent. The classic *nevus*, or port-wine birthmark, generally appears as a reddish-purple stain on the face. Birthmarks are normally harmless, but they can cause people embarrassment and, in some cases, severe emotional distress. Fortunately, there are now new surgical techniques that use laser technology to remove or fade unwanted birthmarks.

Liver spots (or *senile lentigines*) occur most often on the forehead, the temples, the nose, and the backs of the hands of older people. These dark spots, or macules, are for the most part a natural by-product of the aging process, though some people do get them much younger, and some in greater numbers than others. When this occurs, in our society that puts such a premium on youth, some embarrassment can occur; however, most older people simply ignore liver spots just as they might have ignored their first freckles many years earlier.

In this activity, you've had a crash course on the skin. You've looked at the skin's structure along with its apendages, its functions, and a few common features that can show up on the skin of different people. If you're considering a career in the area of home care, you will be especially concerned about common skin disorders and the care of the skin. The next activity will help you.

ACTIVITY 2

Skin Disorders



Do you have pimples or acne? Have you ever had a sunburn? Do you have patches of dry, flaky skin? Have you ever had a wart? A rash? Have you ever suffered a painful burn? Everyone has disorders of the skin from time to time; and most of them, if properly looked after, cause no serious problems. It's possible, however, for serious disorders to develop in the skin, as with any other part of the body. In this activity, you'll be given a brief overview of some of the common types of skin disorders. There are many other disorders of the skin; bear in mind this is a sampling only.

Natural Disorders

Most disorders of the skin occur due to physiological processes. Whether you're talking about blisters, callouses, and corns at one extreme or a malignant melanoma at the other, these are all disorders that occur naturally. Opposed to these are injuries to the skin such as cuts, abrasions, and burns. First of all, you'll be looking briefly at a few representative examples.

Disorders of the Sebaceous Glands

Remember the sebaceous glands? They're the glands in the skin that produce the oily secretion called *sebum*. The sebaceous glands are subject to several disorders among them

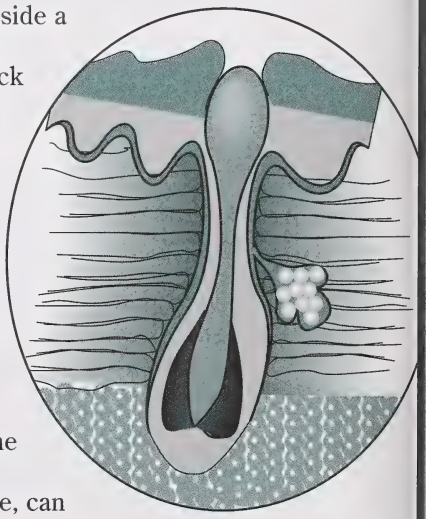
- blackheads
- acne
- seborrhea

blackheads: *hair follicles plugged with oxidized sebum*

acne: *a chronic inflammatory disorder of the sebaceous glands*

Pimples, **blackheads,** and **acne** are disorders familiar to teenagers in particular. These conditions normally occur at puberty and can last through young adulthood Over 80 percent of teenagers are affected by them to some degree—from the odd small pimple or blackhead to severe, chronic acne.

A blackhead occurs if sebum accumulates beside a hair follicle and then oxidizes. The resulting hardened plug is what appears as a small black speck in the skin. Blackheads appear most frequently on the face, especially the forehead and nose.



If a follicle plugged with sebum ruptures and spills sebum into the surrounding skin, more serious problems can occur. The irritated skin can develop *pustules* that can become inflamed and infected. The result might be only a small, single pimple that lasts a few days and then diappears. In some cases, a great many follicles can become plugged and inflamed resulting in a severe infection. An infection of this sort, called acne, can cause permanent scarring.

I thought pimples and acne were caused by eating fatty foods and not washing properly.

This has been the traditional belief, but there's not much evidence to back it up. The real culprits behind acne are the sex hormones called *androgens*. They're secreted first at puberty, and they encourage the rapid production of sebum. Eating a healthy diet and keeping clean may help with small batches of pimples, but anyone with severe acne should see a doctor and get medical help.

eborrhea: *a disorder of the baceous glands sulting in shiny tches, crusts, nd scales*

Another fairly common disorder of the sebaceous glands is **seborrhea.** With this condition, an excessive production of sebum on the head, face, or trunk results in shiny, oily patches. You may be familiar with patches like this on the forehead or nose especially. Seborrhea becomes more serious if sebum accumulates and forms crusts or scales.

1. a. Are you bothered by pimples? blackheads? acne? seborrhea? Or do you know other people who are?

   b. In your experience, how do most teens attempt to treat these conditions? In your answer, try to assess the success of these attempts.

Compare your answers with those in the Appendix, Section 3: Activity 2.

Boils

oils: *raised stules on the in caused by aphylococcus cteria spherical cteria arranged grape-like usters)*

Boils are round, raised, reddened lumps caused by staphylococcal bacteria. Small boils generally go away on their own as the body's immune system overcomes the bacteria, but some may erupt and release the fluids inside before disappearing. One thing to remember about boils is that you shouldn't squeeze them because this can force the bacteria into surrounding tissue, thereby making the situation worse. It is a good idea, though, to cover a boil with a sterile dressing to prevent the infection from spreading. A large boil, or a patch of several boils, may require an antibiotic cream or ointment prescribed by a doctor.

Warts

wart: *a small, hard growth on the skin caused by a virus*

Have you ever had a **wart**? Most people have at one time or another. Some people seem more susceptible than others, and people can be more susceptible to warts at different times of their lives. There are several different types of warts, but they are all caused by a virus that causes the cells of the epidermis to increase in number causing a bump on the skin. Common warts, often the hands and fingers, will generally go away on their own if given time. Creams and ointments that are purchased over the counter in pharmacies and are applied regularly will usually get rid of a common wart. If you're in a hurry, a doctor can kill a wart by freezing or burning it off.

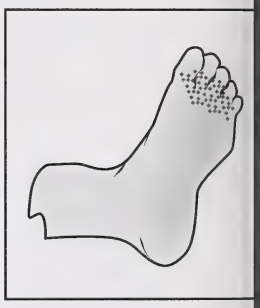
plantar warts: *warts normally appearing in clusters on the sole of the foot*

More problematic are **plantar warts**, which occur on the sole (plantar surface) of the foot, often in large numbers. Because we put a great deal of pressure on our feet when we walk, plantar warts can become painful; they should be treated by a doctor. Like any wart, plantar warts are contagious, so care should be taken not to contract or spread the virus.

Athlete's Foot

athlete's foot: *a fungal infection that occurs between the toes and on the sole of the foot*

Even if you have never had **athlete's foot**, chances are that you know someone who has. This very common disorder is a fungal infection that usually sets in between the toes, where warmth, moisture, and folds in the skin create the breeding conditions it requires. It may remain between the toes, but it can sometimes spread over the whole sole of the foot. A person with athlete's foot finds that the upper layers of skin peel away exposing a shiny, red layer below. This is accompanied by itching and some pain.



Because it's caused by a fungus, athlete's foot is contagious; it can be spread in places like public showers, swimming pools, and gymnasiums. It can also be caught by wearing infected shoes. Fortunately, most cases of athlete's foot can be treated by over-the-counter anti-fungal medications; a sufferer should also use powder and frequent changes of socks to keep the feet dry. Careful drying between the toes after bathing also helps. Serious cases of this disorder should be treated by a doctor.

Psoriasis

psoriasis: *an inflammatory skin condition characterized by scaly red patches*

corticosteroids: *strong anti-inflammatory drugs*

Psoriasis is a fairly common skin disorder characterized by patches of red, dry, scaly skin. It occurs most often on the scalp, elbows, knees, chest, and lower back and can range from a few isolated patches to a widespread skin condition. In most cases, however, it remains fairly isolated. Psoriasis results when the epidermis produces too many new skin cells; these immature cells flake off like dandruff. The precise cause of psoriasis isn't known, and the condition is notoriously resistant to treatment. The treatments that are used generally try to control the symptoms rather than cure the condition. **Corticosteroids** are often prescribed to suppress inflammation.

Psoriasis isn't dangerous, but it causes discomfort and can itch badly. Also, people with advanced cases can suffer embarrassment. Psoriasis isn't contagious, but it does seem to run in families. As noted in the preceding paragraph, doctors usually treat psoriasis with corticosteroid ointments, which act on the body's immune system. This treatment helps, but it controls the symptoms rather than cure the condition. More recently, treatments involving the use of ultraviolet rays have been successful in controlling psoriasis.

Eczema

czema: *an llergic nflammation of he skin causing ching, redness, nd scaly patches*

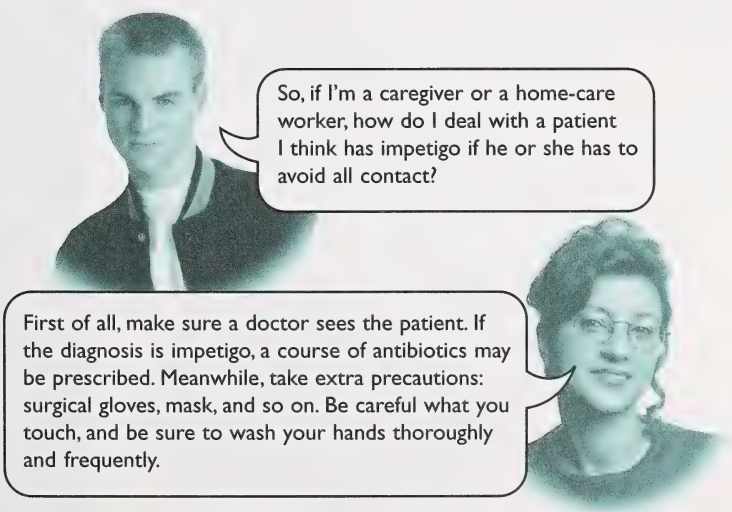
Eczema is another fairly common skin disorder. It's generally caused by an allergic reaction of the skin to some allergen, perhaps pollen, dust, or animal dander. When the blood vessels take the **allergen** to the skin, antibodies are produced; and the battle that follows results in highly inflamed patches of itchy skin. Because eczema is allergic in origin, it isn't contagious, but it can cause a great deal of discomfort to the sufferer. If a person with eczema scratches enough, infection can set in. The skin will then ooze and bleed, and crusts will form. Eczema can be treated with corticosteroid creams. Mild cases are often treated at home with calamine lotion which soothes itching. Reducing exposure to the allergen should also alleviate eczema's symptoms.

llergen: *nything causing n allergic esponse in a erson*

Impetigo

mpetigo: *an nfectious disease ausing pustules n the skin*

A more serious skin disorder is **impetigo**, which normally appears on the face, hands, feet, scalp, or extremities. Impetigo is an infection of staphylococcal and streptococcal bacteria, working in combination. The result is the formation of pustules. Impetigo is highly infectious; patients with this condition should avoid contact with others until the condition is cured by a course of antibiotics, usually lasting seven to ten days.



2. Identify the skin disorder described in each of the following:

   a. Elena has red, dry, scaly patches on her elbows that keep producing flakin skin. Her doctor says she can't cure the condition, but can help relieve the symptoms.

   b. Sami has a cluster of small, hard lumps on the sole of his right foot.

   c. Merete has a lump on her shoulder. Her doctor says it's caused by a bacteria, so she should cover it up; but he expects it to go away by itself. If not, he can give her an antibiotic cream or ointment.

   d. Alex has an excessively shiny area on his forehead that recently has starte to form crusts and scales.

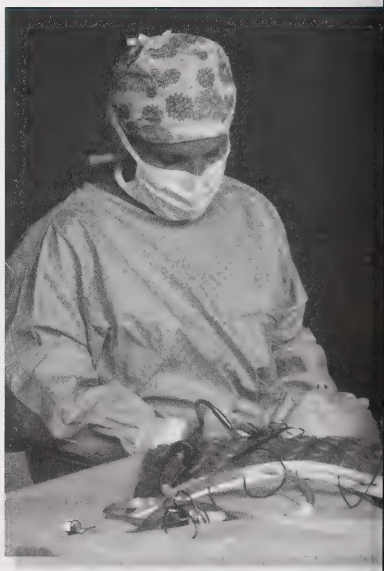
   e. Gschu has patches of itchy red skin. Her doctor says they're the result of a allergy of some sort and aren't serious. He recommends calamine lotion unless they get much worse.

   f. Gavin, finding that his feet have become very itchy, discovers that the top layer of skin between his toes is peeling off, revealing shiny red patches underneath.

   g. Orly has pustules on her skin that her doctor says are caused by bacteria. She's been prescribed strong antibiotics, and her family has been warned not to come into contact with the pustules for ten days.

Compare your answers with those in the Appendix, Section 3: Activity 2.

Skin Cancer



Some skin disorders are very serious indeed and skin cancer is certainly one of them. You've probably heard a lot about skin cancer over the last few years. As mentioned earlier, the thinning of the Earth's protective ozone layer is allowing more of the sun's damaging ultraviolet rays to reach us, and the result is a rather alarming increase in the rate of skin cancer. Some people's love of lying in the sun and tanning in the summer increases the threat. When skin cancer occurs, abnormal cells start multiplying quickly. If they aren't stopped, they'll invade other tissues and the cancer will spread. Eventually, if untreated, the result is likely to be death.

Not all skin cancers are equally life-threatening, though all should be taken very seriously. There are three basic types.

- basal cell cancer
- squamous cell cancer
- malignant melanoma

asal cell skin ancer: *a elatively easily reated, low-spreading ancer beginning n the basal cells f the epidermis*

Basal cell skin cancer, as its name suggests, begins in the basal cell layer (stratum germinativum) of the epidermis. It may appear as waxy gray bumps or a red, scaly patch; sometimes it looks different from either of these patterns.

quamous cell kin cancer: *a elatively easily reated, slow-preading cancer eginning in the pper layers of he epidermis*

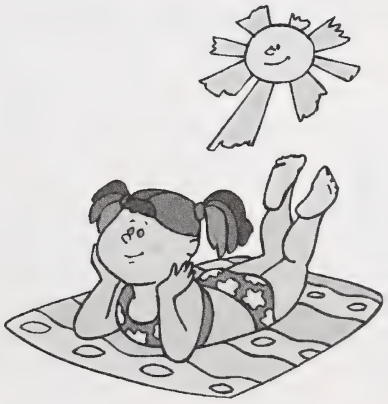
Squamous cell skin cancer begins higher up in the epidermis; it, too, can vary in appearance, but often shows up as rough, scaly patches. Neither of these cancers spreads quickly, though the squamous cell variety is more likely to spread.

Because these two types of cancer are so readily visible and tend not to spread as rapidly as some forms, they're usually successfully treated without much problem. Generally years of exposure to the sun, such as an outdoor worker might have, can cause these cancers. For that reason, they often show up on the hands, forehead, or other area that's frequently exposed.

nalignant nelanoma: *a ighly malignant cancerous) umour eveloping in the ells that form nelanin in the kin*

The third type of skin cancer is far deadlier than the first two, but it's also less common. **Malignant melanomas** often begin in patches that look like moles or are, in fact, moles. When you were told earlier to watch out for moles that were growing, changing shape, or exhibiting colour changes on an irregular shape, it was this form of cancer that was at issue.

Melanomas can show up on any part of the body, but they often appear in areas that are generally covered but may get some intensive sun exposure during the suntanning months. And once they appear, they spread very quickly to other tissue in the body. If you see a mole that you think may be a malignant melanoma, don't waste any time getting to a doctor. If caught and treated early, this form of skin cancer can be stopped, but the word "early" is often crucial.



3. In Activity 1, you were asked to think about ways of protecting yourself from the cancer-causing rays of the sun. If you have access to the Internet, check ou the website of the Canadian Dermatology Association. The address is

http://www.dermatology.ca/english/sun/index.html

When you've reached the site, click on the Sun Awareness button and check out the tips and facts. Sun awareness must start at an early age—lifestyle habits are se as toddlers.

Burns

So far, you've been looking at a sampling of naturally occurring skin disorders; bu the skin is also subject to harm from accidental injuries. Cuts and serious scrapes are obvious examples; they break the natural barrier the skin creates between you and the world and can allow germs to enter the body. For this reason, wounds and scrapes should be carefully cleaned and, if serious, covered with a sterile pad. Some wounds, of course, require a doctor's attention and may require stitches. Possibly you may require a tetanus shot if the object that cut you could have been in contact with that bacteria.

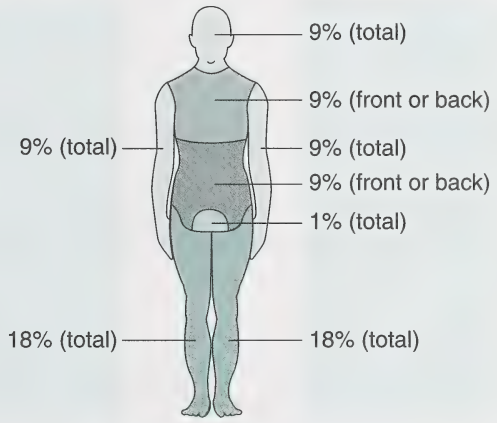
Just about the most potentially damaging injury the skin can receive is a burn. Burns vary from superficial, isolated traumas to the epidermis to deep, life-threatening damage covering large areas of the body. House fires, explosions, accidents working with solvents and fuels—these are some of many causes of severe burns; and emergency ward health-care professionals know all too well hov common—and how devastating—severe burns can be. A burn destroys the skin; and when this happens, it's protective function is lost. The result can be serious shock and infection. Severe burns also cause excrutiating pain and can scar the body permanently.

Health-care professionals use two methods when assessing the damage sustained by a burn victim:

- the extent of the damage over the surface of the body
- the depth of the burn into the skin and tissues lying below the skin

***ıle of nines:** a ethod of timating the tent of surface ea affected by a ırn*

To calculate the extent of the destruction of the skin, a method called the **rule of nines** is often used. It provides a rough, but useful, way of estimating the surface area that has been burned. The rule of nines simply estimates the extent of damaged surface area affected by measuring it as a percentage of the total surface area of the body. When worked out roughly, the body surface can conveniently be divided into areas each of which makes up about 9 percent (or a simple multiple of 9 percent) of the total surface. The accompanying illustration illustrates this.



4. A patient is admitted to the burns unit of a hospital with severe burns to his right arm, his lower torso and groin, and half his right leg. Using the rule of nines, approximately what percentage of his body surface has been damaged?

Compare your answer with the one in the Appendix, Section 3: Activity 2.

One problem with the rule of nines is that the relative size of people's body parts changes as we age. For instance, a baby's head makes up a much greater proportion of the total body than an adult's does. A more sophisticated method than the rule of nines, called the Lund-Browder method, can be used to give a more accurate estimate because it takes into account the age of the victim. The principle is still the same, however: using percentages of the total surface area of the body.

The rule of nines provides a method of estimating the extent of the damage caused by a burn, but the depth of the damage is just as important. A superficial burn to the top layers of the epidermis, for instance, is understandably a far less serious injury than a burn that goes deep into the skin and the tissues lying below it. To classify the depth of a burn, professionals speak of its *degree.* You've likely heard this method being used; almost every newscast describing an accident involving burns announces that "the victim suffered third- [or first- or second-] degree burns." But do you know what these different degrees mean?

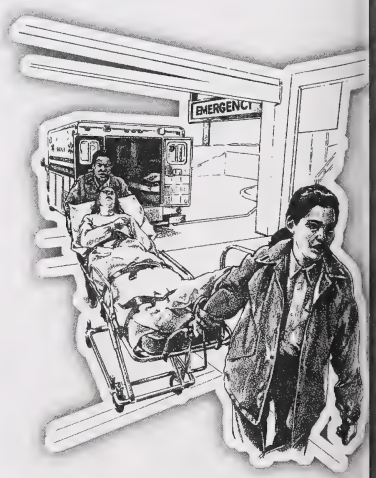
Burns are categorized into three degrees of severity; and it may surprise you to know that a "first-degree" burn is the least, not the most, severe. Simply described, the three degrees are as follows:

- A first-degree burn is one where only the top layers of the epidermis have been affected. A bad sunburn is generally classified as a first-degree burn. Redness and tenderness to the touch are indicators of burns of this sort.

- A second-degree burn is one where much or most of the skin's epidermis has been destroyed, but some remains. In places, second-degree burns probably go right into the dermis. Redness and blistering accompany second-degree burns along with swelling and, later on, perhaps some oozing. If you have briefly touched a hot object, such as an active stove burner, you likely received a second-degree burn. If so, you'll know these burns are very painful indeed.

- A third-degree burn is the most serious kind. A person suffering third-degree burns will have lost all the epidermis in the affected areas and all the layers of skin will have been damaged. As well, the damage may have gone deeper, right into muscles, tendons, and even bones. Whiteness, charring, or both will be likely.

Surprisingly, third-degree burns won't be sensitive to the touch, because the nerves of the skin are destroyed. However, the area surrounding the third-degree burn will be sensitive. As third-degree burns heal, masses of dead tissue may form limiting the movement of the joints.



Third-degree burns can result from explosions or house fires; they can also be caused by prolonged contact with a hot object, by exposure to steam or hot liquids, and by contact with chemicals.

5. Identify each of the following as a first-degree, second-degree, or third-degree burn:

   a. Sierra was horsing around with her younger brother when she fell against the family's wood stove. She got a painful red burn on her arm that soon blistered.

   b. Austin burned his left arm when the solvents he was working with ignited. His arm appeared white with charred areas, but, surprisingly, it wasn't painful to the touch.

   c. Katina wanted to check the oil level in her car, but her hand slipped and came into contact with the hot manifold. Her skin swelled, turned red and blistered and, later on, oozed a bit. It was extremely painful.

   d. Andy decided to start working on his tan slowly, but on his first day at the beach he fell asleep. The result was a painful sunburn.

Compare your answers with those in the Appendix, Section 3: Activity 2.

A person suffering from a severe burn should, of course, be treated by doctors and other health professionals. There are, however, some basic first-aid tips that everyone should know.

- For first-degree burns, cold, wet compresses can be carefully applied to the affected areas. Alternatively, the whole area can be immersed in cold water for about half an hour (or until the pain lessens).

- For second-degree burns, do the following:
  - Cool the burn best by immersing it in a basin of cool water or with cool running water.
  - Don't break any blisters or try to peel off any dead skin or cloth sticking to the burn.
  - Don't use antiseptic creams, ointments, or sprays.
  - Cover the burn with a loose non-stick dressing.
  - Change the dressing if fluid from the burn soaks through. (This is a process you should remember from Section 2.)
  - If the burn involves the victim's arms or legs, try to raise or elevate them.
  - If the burn areas are too large or involve the face, hands, feet, or genital area, call an ambulance or take the victim to a doctor right away.

shock: *a dangerous condition involving a sudden drop in blood pressure and body temperature and which may cause unconsciousness*

- In the case of third-degree burns, the victim may well be in **shock**. Whether or not this seems to be the case, call an ambulance at once. While waiting for it to arrive, do the following:
  - Elevate burned arms or legs so that they're higher up than the victim's heart.
  - Don't apply cold water directly to extensive burns because this may cause shock.
  - Try to get a victim with face burns to sit up.
  - Don't use antiseptic sprays or salves.
  - If the victim is in shock, keep him or her at a comfortable temperature (but not too warm), lying down, with burned limbs elevated if possible; loosen any tight clothing; and take a pulse rate and check breathing from time to time. Stay with the victim until the ambulance arrives.

If you get third-degree burns, what do they do at the burn unit of the hospital?

Burns are treated in different ways. The hospital may use the "open method" whereby the burns are left uncovered, or it may use the "closed method," which involves special salves wrapped in layers of gauze. But there are newer techniques used in some hospitals that involve submerging the burned areas in a silicone solution. Whatever method is used, the goals are to

- combat shock by replacing lost fluids and **electrolytes**
- relieve pain
- prevent infections, deformities, and **contractures**
- provide emotional support

electrolytes: *compounds that help regulate the body's internal chemical balance*

contractures: *shortenings of the muscles*

6. Nicholas sustained second-degree burns to his lower leg. His mother applied antiseptic creams and broke blisters as they occurred, pulling away what appeared to be dead skin. She made sure that Nicholas kept his leg down on the floor so the blood would get to the burned area, bringing necessary oxygen to the wound.

   What advice would you have given Nicholas's mother if you'd been present?

Compare your answer with the one in the Appendix, Section 3: Activity 2.

You now have an idea about some of the common skin conditions a person can get, but if you were involved in providing home care, would you be able to apply what you've learned? Since this is essentially a practical course, it's important that you understand some of the practical aspects of skin care. This is what you'll be getting in the next activity.

ACTIVITY 3

Home Care and the Skin

Anyone involved in home care, whether as a primary caregiver, nurse, or nursing assistant, should pay special attention to the skin condition of care-receivers. You've already seen that the prevention and treatment of pressure sores is an important concern of caregivers. The concerns of people delivering home care go beyond pressure sores. In this activity, you'll get a look at some of the other practical aspects of skin care that those involved in home care should be aware of.

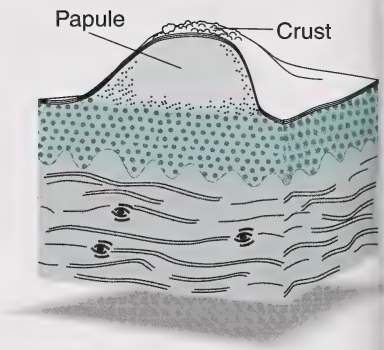
Skin Lesions

***esions:** any abnormal hanges in the issue*

The first things any caregiver should be on the lookout for when it comes to skin problems are skin **lesions**—abnormal changes in the skin. Skin lesions are normally classified into several different categories according to their characteristics. Here are seven of the most common categories—some of which you've already encountered:

- **macules:** small, flat, discoloured spots like freckles or measle rash
- **papules:** small, solid spots that are raised from the skin. They may or may not contain pus. Warts are examples.
- **pustules:** raised spots containing pus. An example is acne.
- **vesicles:** raised patches like blisters that contain fluid. The blisters caused by chicken pox are vesicles.
- **wheals:** large, itchy, swollen areas. Hives and insect bites are wheals.
- **excoriations:** areas of the skin that have been scraped or scratched
- **crusts:** the dried remains of oozing sores. They may or may not contain sebum or pus under the surface.

1. Identify each of the following lesions according to its type.



A Cross-Section of a Papule

   a. Kristen was bitten by a bug and now has a large, raised, itchy spot.

   b. Riley got into some poison ivy and his arms are now covered with small, itchy blisters full of liquid.

   c. Janos has German measles and is covered by small, flat spots.

   d. Ping had several mosquito bites on her leg, and she scratched them until she'd scraped away the skin.

   e. Savannah put on make-up in the morning to hide the pimples that always seemed to develop under her nose.

Compare your answers with those in the Appendix, Section 3: Activity 3.

As you can see from what you've already read, skin lesions can be caused by many different things. For example, allergies can cause lesions. Poison ivy is an example of an allergic reaction of the skin. While most people respond to poison ivy, many allergens will affect some people but not others; different people allergic to the same things will react in different ways. Hives are wheals that are the result of an allergic response.

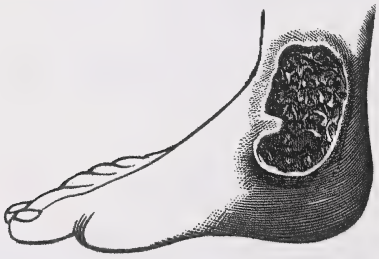
▼

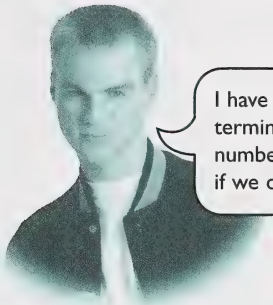
rubella: *a contagious viral infection also known as "German measles"*

▲

Communicable diseases like chicken pox, measles, and **rubella** can also cause lesions. In the case of diseases such as these the lesions are often called *rashes* or *skin eruptions*. Impetigo, a skin condition you've already looked at, is highly communicable.

Of course, as you've already discovered, lesions can be caused by other, less dangerous, causes. Hormones, fungi, and viruses (as in the case of warts) can all cause lesions—as does skin cancer, something that must be dealt with very seriously. And sometimes, as you know, lesions result from pressure on certain parts of the body due to lying or sitting in one position for long periods of time.





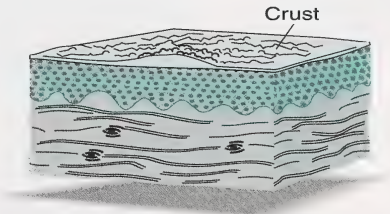
I have a question. Why is it necessary to know all this terminology? I mean, we've alreday learned about a number of skin conditions; what difference does it make if we call a lesion a *macule* or a *vesicle*.

For one thing, simply learning the terms for different types of lesions and what they mean makes you more sensitive to the differences and their implication. For another thing, if you can accurately describe a lesion to a nurse or doctor, you'll be more likely to get an accurate diagnosis quickly.

While being able to describe a skin lesion will often help with an early diagnosis, frequently diagnostic tests will have to be carried out to make sure. These will be ordered by a doctor and carried out in a laboratory. They may involve studying scrapings under a microscope or growing a culture of the lesion if the doctor suspects an infection.

While home-care specialists and caregivers won't be expected to diagnose every skin lesion, they often will be required to help care for them. Some points you should always bear in mind when this happens are as follows:

- Handle patients with skin lesions gently.
- Keep a close eye on the care-receiver's skin, but don't change the dressings unless you've been instructed to by the professional in charge of the case.
- In some cases, soap and lotions are harmful to certain skin conditions. Check this out carefully before bathing the care-receiver or giving a back rub.



A Cross-Section of Crusts

- Don't remove any crusts unless the professional in charge of the case instructs you to.
- Report any changes you notice.

Giving an Emollient Bath

emollient bath: *a tepid bath containing a mild medication that softens and soothes the affected body part*

Frequently a skin condition can be helped by what's called an **emollient bath**—a bath given in tepid (lukewarm) water containing a mild medication such as cornstarch, baking soda, or oatmeal. Here's the recommended process (assuming that the patient can get into and out of the tub).

- Wash your hands and gather your equipment. Wear disposable gloves, especially if there are open lesions.
- Explain what you're doing (especially if this is the first time the patient has had this experience).
- Be sure the bathtub is clean and that the room is nice and warm.
- Fill the tub with (tepid) lukewarm water. If you can, use a thermometer to see that it's about body temperature. If not, use the "elbow test"—if the water is lukewarm on your elbow, it is the right temperature.
- Add the medication and dissolve it thoroughly by stirring.
- Transfer the patient to the tub, and have him or her lie there for at least half an hour but no longer than an hour.
- Using gloves if necessary, gently sponge areas not covered with water, while the patient is lying there.
- Add warm water as needed and ensure that the patient doesn't get cold.
- Help the patient out of the bathtub and pat the skin dry. Don't rub it.
- Apply appropriate lotions, and help the patient get dressed and into bed.
- Carefully clean up the equipment and carefully wash your hands.

2. Mrs. Carruthers is caring for her elderly mother in her home and prepares to give her mother an emollient bath. She fills the tub with steamy water, just the way she herself loves it, adds the medication, stirs it, and goes and gets her mother. Her mother suffers from dementia, and has trouble understanding things, but Mrs. Carruthers hushes her protests, hurries her into the bathroom, and helps her into the tub. Being a busy woman, she leaves her to soak while she does her housework. After an hour and a half, she gets her mother out of the now rather cool water, gives her a brisk rub with a coarse towel and bundles her back into bed.

   If you were helping Mrs. Carruthers, what advice would you give her?

Compare your answer with the one in the Appendix, Section 3: Activity 3.

Pressure Sores: A Second Look

Characteristics of Pressure Sores

In Section 2: Activity 2, you looked briefly at the problem of pressure sores (or bed sores). Because these lesions are so common with patients confined to beds or wheelchairs (especially if they're elderly, thin, obese, or poorly nourished), anyone involved in home care must be especially aware of them. As noted in Section 2, it is far easier to prevent pressure sores than to heal them, and it is easier to heal them when they're just starting than when they are advanced.

lermal ulcer: *ressure sore*

ecubitus lcer: *pressure ore*

lcer: *an open sion, in this ase resulting rom inadequate irculation and roken skin*

Pressure sores (also, by the way, called **dermal ulcers** or **decubitus ulcers**) result when staying in one position interferes with circulation of the blood in an area where pressure is exerted. The first thing to look for is redness on the skin. If nothing is done at this stage, the skin cells will start to die from lack of nourishment, and an **ulcer** appears. If left untreated, these ulcers can become surprisingly deep and broad. They can go through all the layers of the skin and even into muscle and bone.

3. Because pressure sores develop in areas of the body where there is regular pressure on the skin, a caregiver can predict where they will likely occur. This helps in the process of spotting them early. Here's an outline of a human body, as seen from the back. Imagine that this person is a home-care patient who normally lies in bed on her back or sides. Sketch a similar outline and put circles or arrows to indicate where you think pressure sores are likely to occur.

Compare your diagram with the one in the Appendix, Section 3: Activity 3.

Along with the pressure points indicated in the Suggested Answer to question 3, pressure sores can also occur where body parts rub against each other. Some of the common locations are

- knees
- between the buttock folds
- under the breasts
- legs
- ankles
- any folds in the abdomen

As well, any tubing or other equipment that rubs or lies against a care-receiver for an extended period can cause a pressure sore.

Preventing Pressure Sores

Prevention is the best approach to take with pressure sores as indicated in Section 2: Activity 2.

4. Without looking back, see how many of those preventive measures you can recall.

Compare your answer with the one in the Appendix, Section 3: Activity 3.

Following are some additional recommendations for skin care to add to the previous list, especially if the patient is at risk for pressure sores:

- Perform a thorough check of the skin daily.
- While working with a patient, take every opportunity to check over spots on the patient's body where pressure sores are likely to occur.
- Change the position of the patient every four hours (every two is better). Make sure this is a real change, so the pressure points shift, but avoid friction during the process.
- If a patient is incontinent, remove any urine or feces from the skin as soon as possible.
- Watch out for hard objects like crumbs in the bed.
- Position equipment or tubes so they don't rub or create pressure.
- Massage around any reddish areas with a rubbing lotion, but not directly on the site (and don't use alcohol).
- Do not apply lotions to any open sores.
- Use cornstarch on friction areas, but only a dusting. Do not let it cake up.
- At least twice a day, have the patient go through several exercises to improve circulation.

Treating Pressure Sores

Prevention is the key with pressure sores. If one is allowed to develop past its initial stage of redness, it will be difficult to treat. Still, there are things that can be done. The development of pressure sores can be broken down into four stages with each stage requiring its own treatment as follows:

Stage 1: If you spot a sore beginning, it will be red or possibly blue-grey. First get the pressure off the sore and massage *around* it. Keep it clean and dry and remember the importance of nutrition and liquids. Any broken skin should be kept covered with sterile dressings. Keep an eye out for infections, and be sure to report them to the health professional in charge. This person may prescribe antiseptic or antibiotic ointments or even a special mattress.

Stage 2: At this stage, the redness has increased and there are blisters appearing The skin may be broken, but not necessarily. Continue treatment as in Stage 1, but now it is even more important to notify a nurse and to keep records of any changes.

Stage 3: Now all the layers of skin are affected and a nurse should be assessing and monitoring the situation because an ulcer is forming. The same things recommended for the first two stages should be continued, but more should be done. Probably a nurse will wash the lesion with special cleansers under a doctor's orders. As well, ointments may be prescribed to help remove dead tissue along with agents that promote the growth o healthy tissues and decrease the spread of infection. Special dressings will likely be ordered that must be changed regularly. Bathing may also be prescribed (in a whirlpool bath, if possible). In severe cases, surgery may be used to close the ulcer at Stage 3.

Stage 4: At Stage 4, the ulcer has gone right down into the tissues lying below th skin, perhaps into the bone itself. Everything that was recommended in the earlier stages still applies, but the situation must be constantly assessed and the ulcer measured. Until healing is complete, the bed sor must be treated with constant attention and assessment.

Wow, I had no idea pressure sores were so serious! I mean, they didn't sound that bad. Bed sore. Pressure sore. They sound like some little irritation that you just put up with.

By no means; they're very serious problems indeed. Perhaps if we made a point of calling them *dermal* (or *decubitus) ulcers,* people would take them more seriously. These days patients at risk of developing pressure sores in hospitals can get special high-tech mattresses that pretty well eliminate the chance of sores developing, but most home-care patients are still in more traditional beds.

5. You've encountered a pressure sore that extends through all the layers of the skin.

   a. What stage has it reached?

   b. Recommend treatment for this sore.

Compare your answers with those in the Appendix, Section 3: Activity 3.

You may be familiar with the care of fingernails and toenails. If you find yourself looking after a care-receiver who needs this type of help, you'll no doubt find yourself doing this job on a regular basis. This is the kind of job that is easy for a busy caregiver to neglect; and it can sometimes seem to be something postponed. For this reason, you should establish a routine and do the job once every week.

Nails should be kept clean, short, and smooth; that way, they'll appear attractive and they won't risk damage to the patient's skin. Short nails are also easier to cut than longer ones; there's less chance of splitting. Elderly patients sometimes have thick, brittle nails that are hard to trim even when kept short; in these cases it helps to soak them in warm water before trimming. The following steps outline the basic procedure used in trimming a patient's fingernails or toenails:

- Assemble your equipment. You will need the following supplies:
  - clippers (Do not use scissors.)
  - a file or emery board
  - an **orange stick,** if available
  - a basin of warm water
  - a towel
  - hand lotion

orange stick: *a slim stick used to gently clean under nails and push back the cuticles*

- Wash your hands.
- If the procedure is new, explain to the care-receiver what you're going to do.
- Protect the bed with a towel and place the patient's hands or feet in warm water.
- After a few minutes of soaking, clean under the nails with the orange stick.

- Dry the hands or feet.
- Use the clippers to carefully trim the nails.
- File down any rough edges with the file or emery board.
- Massage the hands and feet with lotion.
- Repeat these processes until all the nails have been dealt with.
- Put away your equipment and wash your hands.

Note that some patients, such as those with diabetes, should have their nails trimmed by a health-care specialist. This is because their blood circulation can be impaired and they will heal slowly if cut. It is especially important for people with diabetes to have proper nail care.

6. With the help of a classmate, friend, or family member, practise the steps involved in trimming toenails or fingernails. Then reverse roles so you experience what it feels like to have your own nails cut by someone else.

Compare your answer with the one in the Appendix, Section 3: Activity 3.

With this look at nail care, Activity 3 has come to an end. In this activity, you have learned something about the practical aspects of caring for the skin in a home-care situation. In particular, you've learned about classifying and recognizing lesions, about giving emollient baths, and above all, about preventing and caring for pressure sores. Any caregiver must, of course, be concerned about the entire health of that patient; but the skin is something that must be given special attention. You should now have a better idea about what this process involves.

FOLLOW-UP ACTIVITIES

If you had difficulty understanding the concepts in the activities, it's recommended that you do the Extra Help. If you have a clear understanding of the concepts, it's recommended that you do the Enrichment.

Extra Help

The skin is a semi-translucent, elastic organ containing a vast number of capillaries. The blood flowing through the capillaries gives the skin its rosy colour. Melanin, a pigment stimulated by exposure to sunlight, also provides colour for the skin.

1. The skin is made up of three layers. Identify them, from superficial to deep layers. Try to do this without looking back if possible.

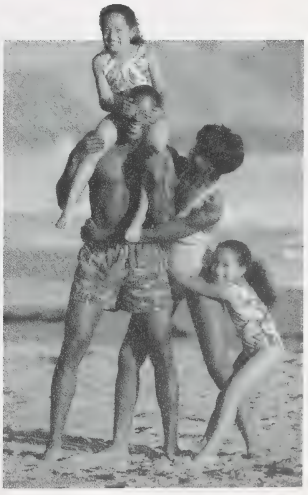
2. The outer layer of skin, the epidermis, has five distinct cell layers.

   a. Match the scientific names for these layers from the list on the left with the common names from the list on the right.

(1) stratum corneum	A. clear cell layer
(2) stratum spinosum	B. basal cell layer
(3) stratum granulosum	C. flat, dead cell layer
(4) stratum germinativum	D. prickly cell layer
(5) stratum lucidum	E. granular cell layer

   b. Now arrange the cell layers, using either the scientific or common names, in their correct order, starting at the surface and working down.

3. Keratin is a tough elastic protein that hardens skin cells and helps make them waterproof.The skin has two appendages that have large amounts of keratin. What are they?



4. Sunlight can be very harmful to the skin if there's too much exposure, but the skin does require some exposure to the sun. Why is this?

5. Read the following descriptions of common skin disorders and identify the condition described.

   a. small, hard growths on the soles of the feet caused by a virus

   b. patches of red, dry, scaly skin occurring usually on the scalp, elbows, knees, chest, and lower back

c. a contagious infection of the skin caused by staphylococcal and streptococcal bacteria

d. a mole or a mole-like lesion that has turned cancerous

e. a hair follicle plugged by oxidized sebum

6. Harrison suffered burns over almost all of his left arm when he turned the valve on his gas barbecue the wrong way. In places, the burns went right through the skin and into the tissues below, but his arm wasn't sore to touch except for the area surrounding the burn.

   a. According to the rule of nines, what percentage of Harrison's body surface has been affected?

   b. Would Harrison's injuries be classed as first-degree, second-degree, or third-degree burns?

   c. If you were with Harrison at the time of his accident, what would you do?

7. Without looking back, try to list at least **six** things you could do as a home-care provider to minimize the chance of your care-receiver getting dermal ulcers.

Compare your answers with those in the Appendix, Section 3: Extra Help.

Enrichment

Do **one or more** of the following:

1. In Activity 3, you were presented with seven common skin lesions. These seven were selected as representative of the variety of lesions that can occur on the skin; however, things are really more complex than that. If you'd like to learn a bit more about the classification of skin lesions, the material that follows will get you started.

   Skin lesions are ordinarily divided into two types: primary and secondary. Primary lesions develop first; if they're left untreated, secondary lesions may develop. For example, a dry patch of skin may develop near the corner of your mouth. This is a primary lesion. If you don't moisturize this patch and it dries out even more, a crack, or fissure, may appear. This fissure is a secondary lesion.

Primary lesions are ordinarily classified into 12 categories and a brief summary of all 12 follows. You will recognize some of them from Activity 3.

- Macules are small, flat discoloured markings such as freckles. Macules stay flat, but they can be as large as 1 cm in width.

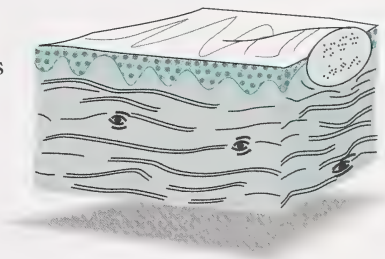
- Patches are macules wider than a centimeter. Patches have distinct edges (or, to use correct teminology, they're *circumscribed.*)

- Papules are small, solid lesions that are elevated above the skin. They usually have no fluid, but they may contain a bit of pus. Warts and some acne are examples of papules.

- Wheals are itchy, swollen lesions that normally last only a few hours. They're usually solid, resulting from a swelling of the epidermis. Hives and insect bites are wheals.

- Nodules are small, solid lumps above or beneath the skin's surface. Nodules are 1 cm in width or smaller.

- Tumours are simply nodules that are larger than 1 cm across. Being larger, they can go deeper than nodules, perhaps into the subcutaneous tissue. Tumours are circumscribed.



A Cross-Section of a Nodule

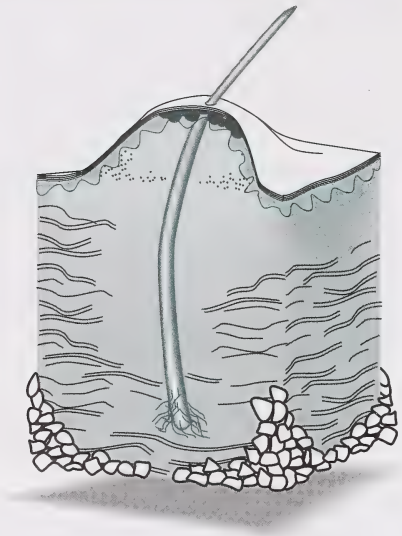
- Vesicles are circumscribed raised spots containing clear, watery fluid and are as wide as 1 cm. Vesicles lie within or just below the epidermis. Small blisters and chicken pox lesions are vesicles, as are the sores resulting from contact with poison ivy.

- Bullae are much like vesicles only larger. The blisters resulting from second-degree burns are usually classified as bullae.

- Pustules are circumscribed elevations of the skin containing pus. They vary in size. Pustules are usually associated with hair follicles. Acne and impetigo give rise to pustules.

- Cysts are lumps that are either semi-solid or filled with fluid. Cysts can be on the surface of the skin or below it, and usually form due to the blockage of a capsule. Cysts vary in size from something as small as the head of a pin to something as large as a fist. In severe cases of acne, cysts can form.

- Furuncles are large, raised, and localized infections of the hair follicles that are usually caused by staphylococcal bacteria. They appear on the surface of the skin. Boils are typical furuncles.



A Cross-Section of a Furuncle

- Carbuncles are extreme infections of several adjoining hair follicles; they can lie below the skin or be on the surface. Carbuncles drain through multiple openings on the skin's surface.

a. Identify each of the following primary lesions according to type:

(1) mosquito bites
(2) chicken pox sores
(3) freckles
(4) acne
(5) second-degree burn blisters
(6) boils
(7) warts

Compare your answers with those in the Appendix, Section 3: Enrichment.

Secondary skin lesions develop after primary ones. What follows describes five common secondary lesions:

- Scales are dry, plate-like cells of the stratum corneum layer. They're usually whitish or brownish in colour. Scales may be dry or greasy. Dandruff and psoriasis lesions are examples of scales.

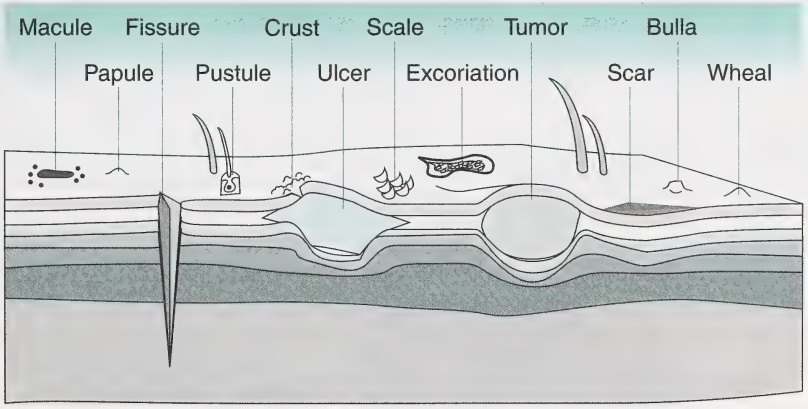
- Crusts, or scabs, are the dried remains of an oozing sore. They sometimes contain sebum or pus.

- Excoriations are skin sores or abrasions produced by scratching or scraping the skin. These lesions are usually superficial. Scratched insect bites or scabies lesions are examples of excoriations classified as secondary lesions.

- Fissures are almost straight-line breaks or cracks in the skin. Fissures may go right through the epidermis and into the dermis. They commonly appear around fingertips and the backs of the heels, where callouses occur.

- Scars are likely to form after the healing of an injury or a skin condition that has penetrated the dermal layer. Scars occur when connective tissues replace tissue lost through injury or disease.

b. The diagram that follows shows a number of primary and secondary lesions. Without looking back, if possible, try to classify each one as either primary or secondary.



Compare your answers with those in the Appendix, Section 3: Enrichment.

2. Earlier in this section, you were referred to the website of the Canadian Dermatological Association. If you have access to the Internet, go back to tha site now (**http://www.dermatology.ca/english/sun/index.html**) and look around for more information on protecting yourself from the harmful rays of the sun. Try hitting the "CDA News" button first; then press each of these buttons:

   - "Play Smart"
   - "Eyes and Sunscreen"
   - "Sunscreen Usage"

3. Whether or not you were able to do question 2, you should be able to gather a good deal of information on the relation between skin cancer and overexposure to the sun. If so, create a pamphlet or poster reminding people how to deal with sunshine safely and what to watch for in the area of skin changes that might be warning signals. Make sure your friends and family members see your pamphlet or poster and encourage them to study it carefully.

4. Once again, if you have access to the Internet, d some surfing and see what you can learn about any of the skin conditions discussed in this section. There are many websites devoted to health matters. You might begin your search simply by using keywords with your favourite search engine. If your search engine is Yahoo Canada (**http://ca.yahoo.com/**), you can go right to the title *Health* and begin a more specifi search.

   This will give you a number of excellent health sites to investigate.

CONCLUSION

In this section, you have shifted gears and had a look at the human integumentary system—the skin. You've seen the different layers of skin along with the skin's functions and features. You've looked at a number of skin conditions and diseases, and you've learned something about caring for the skin. Finally, you've seen how important it is for home-care providers to know the basics of the integumentary system.

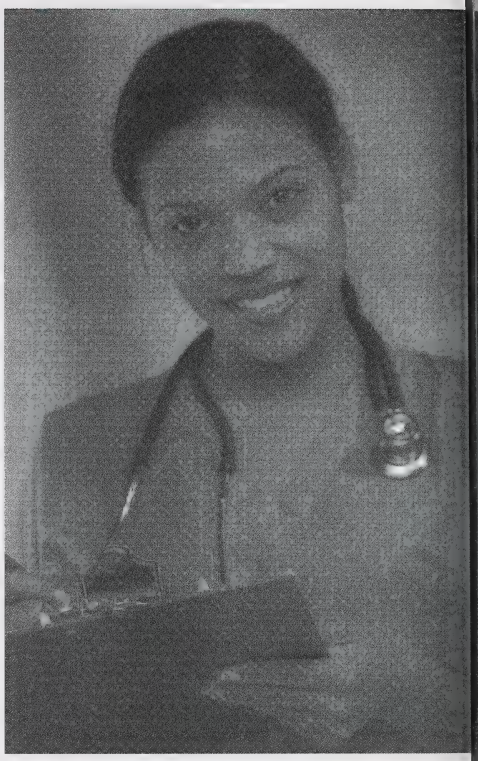
Do you remember the introduction to Section 3? There, you were told about Mr. Thibodeau and his daughter's rash. At this point, do you have any suggestions for Mr. Thibodeau? When a baby develops a rash and there's no fever, it's probably an allergic reaction to something—perhaps the child's clothing or diet. It may also be a heat rash, in which case, removing some clothing and giving the child a bath may help.

Of course, no one could expect you to be able to diagnose the baby's skin condition from the little bit you've learned in this section, but it's possible that you've developed some interest in the skin and the science of dermatology. Who knows? You may end up a doctor or a nurse with specialized knowledge in this area. Even if you don't, what you've learned should help someday with your own family or simply with the responsibility we all have of looking after our own health.

ASSIGNMENT

Turn to Assignment Booklet B and do the assignment for Section 3.

S • U • M • M • A • R • Y



Congratulations! You've completed Community Health 1060: Home Care 1. At this point, you should know a good deal about the basics of home care. You should understand what home care is, who it's for, and how it works. You should also be aware of the role of the primary caregiver, other family members, and the health-care professionals and aides who supervise and assist with home-care delivery.

You may be taking this course because you're thinking of possibly working in this area someday; or you may simply wish to learn more about looking after someone in your own home. Either way, you've learned a lot. Whether it's how to set up a room, access community resources, take vital signs, care for the skin, deal with the stresses involved in being a caregiver, or some other related task, you're now in a good position to lend a hand and contribute knowledgeably to the process.

Of course, there's a great deal more to be learned about the business of home care; this is, afterall, only an introductory course. If you wish to learn more, mak inquiries about Home Care 2 and Home Care 3. If these courses are offered at yo school, they'll teach you much more. If you're thinking of a career in this area, they'll give you an excellent grounding for future studies.

APPENDIX

Glossary
Suggested Answers
Image Credits

Glossary

acne: a chronic inflammatory disorder of the sebaceous glands

acute: severe, brief, critical, and urgent

albinism: a condition caused by a congenital failure of the skin to produce melanin, or pigment

allergen: anything causing an allergic response in a person

Alzheimer's disease: a degenerative disease of the brain and nervous system that causes dementia (a deterioration of mental processes) in affected individuals

apocrine glands: sweat glands responsible for body odour

athlete's foot: a fungal infection that occurs between the toes and on the sole of the foot

basal cell skin cancer: a relatively easily treated, slow-spreading cancer beginning in the basal cells of the epidermis

bed blocks: blocks used to raise a bed so as to make it easier for a patient to get in and out

bed cradle: a device used to prevent the weight of the bedclothes from resting on some part of the body

bedside commode: a portable toilet

blackheads: hair follicles plugged with oxidized sebum

boils: raised pustules on the skin caused by staphylococcal bacteria (spherical bacteria arranged in grape-like clusters)

capillaries: tiny blood vessels connecting arteries and veins

chronic: lasting a long time

contractures: shortenings of the muscles

convalescence: the process or period of recovering health after an illness or injury

convalescent: a person who is healing or recovering from an injury or illness

corticosteroids: strong anti-inflammatory drugs

crusts: the dried remains of oozing sores which m contain sebum or pus below the surface

decubitus ulcer: pressure sore

dementia: an abnormal deterioration of the mental processes

dermal ulcer: pressure sore

dermatologist: a doctor specializing in conditions the skin

dermis: the layer of skin between the epidermis ar the subcutaneous tissue

diversion: an amusement or pastime that makes th time during illness or convalescence more plea

eccrine glands: sweat glands that produce a water cooling secretion

eczema: an allergic inflammation of the skin causin itching, redness, and scaly patches

electrolytes: compounds that help regulate the bod internal chemical balance

emollient bath: a tepid bath containing a mild medication that softens and sooths the affected body part

epidermis: the outer layer of skin

expiration: breathing out (exhalation)

footboard: a padded device used to keep a bed-patient's feet properly positioned

hair follicle: a small, hollow structure from which a hair grows

hand roll: a soft ball or some substitute with which patient can exercise the hand muscles

hip roll: a rolled-up sheet or blanket placed tightly beside a bed patient to keep the body properly aligned

home care: the care of people who are sick, injure disabled, or dying, and who are unable to look a themselves, that takes place in the home rather than in a care facility

impetigo: an infectious disease causing pustules on the skin

incontinent: unable to control the bladder and/or bowels

inspiration: breathing in (inhalation)

integumentary system: the organ of the body comprised of the skin and its appendages (hair, nails, sweat glands, and oil glands)

keratin: a protein that hardens skin cells when they die

legumes: foods like peas, beans, and lentils, which are all seeds of plants of the pod-bearing family

lesions: any abnormal changes in the tissue

macules: small, flat, discoloured spots like freckles or measles sores

malignant melanoma: a highly malignant (cancerous) tumour developing in the cells that form melanin in the skin

melanin: the pigment in the skin which gives it its colour

oral thermometer: a clinical thermometer designed to be inserted into the mouth

orange stick: a slim stick used to gently clean under nails and push back the cuticles

palliative care: care provided for patients with terminal conditions and intended to alleviate their suffering rather than provide a cure

parish nurse: a registered nurse and member of the ministry team who helps members of the congregation to become more aware of their health and move toward a fuller sense of wholeness

papules: small, solid spots that are raised from the skin and which may or may not contain pus

pigmentation: colour

plantar warts: warts normally appearing in clusters on the sole of the foot (plantar surface)

pressure pads: soft items like pillows used to prevent irritation to the skin in places where pressure sores are likely to develop

pressure sores: dermal ulcers or bedsores: sores that occur on the skin when circulation is slowed down by extended pressure or friction on a part of the body

primary caregiver: the person in a household providing home care who provides most of the care and assumes the ultimate responsibility for looking after the care-receiver

psoriasis: an inflammatory skin condition characterized by scaly red patches

pulse rate: the number of times a person's heart beats in a 60-second interval as measured by feeling the surge of blood in the arteries

pustules: raised lumps on the skin containing pus

rectal thermometer: a clinical thermometer designed to be inserted into the rectum

rehabilitation: the process of restoring to a former state of health and activity

respiration: breathing (technically, one inspiration, one expiration, and the pause following an expiration)

respiration rate: the number of breaths a person takes in a 60-second interval

respite care: care provided for a primary caregiver who needs a break from the stresses of providing home care

rubella: a contagious viral infection also known as German measles

rule of nines: a method of estimating the extent of surface area affected by a burn

sebaceous glands: glands in the skin that produce the oily substance sebum

seborrhea: a disorder of the sebaceous glands resulting in shiny patches, crusts, and scales

sebum: the oily substance produced by the sebaceous glands

shock: a dangerous condition involving a sudden drop in blood pressure and body temperature which may cause unconsciousness

sitz bath: a bath taken in a sitting position in a small tub so that only the buttocks and hips are immersed

squamous cell skin cancer: a form of skin cancer, relatively easy to treat, beginning in the upper layers of the epidermis

stratum corneum: the outer layer of the epidermis

subcutaneous tissue: the layer of the skin made up of fatty tissue lying below the dermis

terminal hairs: the relatively coarse hair that grows in specific areas of the body

transfer belt: a wide, heavy belt used around a patient's waist to transfer him or her from one surface to another

ulcer: an open lesion resulting from inadequate circulation and broken skin

vellus hair: the fine, soft, wispy hair that covers most of the body

vesicles: raised patches like blisters that contain fluid

wart: a small, hard growth on the skin caused by a virus

wheals: large, itchy, swollen areas on the skin due allergic response

Suggested Answers

Section 1: Activity 1

1. There are several reasons for this, but the one that stands out most is the simple fact that modern medica advances mean that people are generally living to be older. With more elderly people to look after, the health-care system is finding it difficult to cope. Nursing homes are crowded, and waiting lists can be lon therefore more and more families are going back to the traditional practice of caring for elderly family members at home. This problem promises to become even more extreme as the so-called "baby boomers born after World War II, approach their senior years.

   Another factor is that health-care costs have soared in recent years, and governments are finding the system difficult to fund. To cut costs, patients are sent home from hospitals earlier than usual to the care of their families—hopefully with the supervision of trained health-care professionals.

   Did you come up with other ideas?

2. a. Taka was clearly bored and frustrated, and he took his feelings out on his family. Feeling lonely and helpless and unable to do the things he enjoyed, he became angry and negative.

   b. Answers will vary. You may have thought of the following ideas:

      - Normal routines will be upset as Taka will need frequent doctor's appointments.
      - Family members will have to undertake additional responsibilities like helping Taka bathe and get dressed.
      - Family members will have to take over Taka's chores, such as, shovelling snow or taking out th garbage.
      - Taka's mood changes are also likely to upset the family.
      - Taka's illness will likely become the central preoccupation of the family. He'll need help with many tasks, and household furniture may have to be rearranged to accommodate his needs.

   Did you think of anything else?

Answers will vary. Compare your ideas with the ones that follow:

- Normal routines will be disrupted as Grandpa Carlos will need constant supervision. Careful planning will be required to make sure that someone is always at home with him.
- Family members will need assistance from health-care professionals and community organizations for providing medical attention and the oxygen needed for Grandpa's care.
- Some members of the family must be prepared to help Grandpa with the daily chores he's no longer able to do. This will include such things as personal hygiene and eating.
- Family members may experience additional stress while monitoring Grandpa's progress. Matthew may be disappointed to find that his grandfather isn't always well enough to play games as he used to do.
- The family may have to rearrange household items and add safety devices for Grandpa to use. The bathtub and toilet may need safety bars. As you know, Matthew will have to give up his bedroom for Grandpa to stay in.
- Grandpa's medications will have to be stored safely and administered precisely as directed by the doctor.
- There may be additional company in the household as friends and health-care professionals stop in to see Grandpa.
- Grandpa may become despondent and not care about his future. The family members must be prepared to respond to his emotional needs as well as his physical ones.
- Family members will have to learn techniques to assist Grandpa with body positioning.

You likely thought of a few other points to mention.

Answers will vary. Here are a few ideas:

- Finances will be a real concern. Mrs. Kquan will certainly qualify for assistance through Workers' Compensation, and she might have private insurance, but it will be necessary to determine just how the family income will be affected and make adjustments accordingly.
- The family will likely have to rely on neighbours, friends, and relatives to provide transportation for the children and to help out in the household.
- Family members will have to help Mrs. Kquan get around the home and look after her needs.
- Mrs. Kquan will require a long period of physical therapy after her initial recovery period, and the family may have to help her with her exercises.
- The family will probably have to consider adaptations for the home and acquire the equipment Mrs. Kquan will need to get around the house.
- Each member of the family is almost certain to experience stress over Mrs. Kquan's future and about the additional responsibilities involved in running a household.

Did you have any other ideas?

Section 1: Activity 2

1. Answers will vary. Here are a few things you might have considered:

   - Don't expect miracles; recovery can be a long, tedious process. Expect some setbacks.
   - Caregivers should remember that they have needs too. They should ensure that they get some tim to themselves to renew their energy levels.
   - Members of the family should each have specific duties assigned them or certain times of the day when they're on call, with a system that has some flexibility.
   - Allow time for new routines to be established and family members to adjust.

   No doubt you thought of other points to add to your list.

2. Answers will vary. Perhaps you're entirely unfamiliar with this concept, but more and more research seems to be pointing to the importance of attitude and mind set when it comes to physical healing. It seems that a positive attitude promotes recovery while a negative one slows the process down and increases the chance that no recovery will take place. Why this is so isn't really understood; perhaps it h to do with chemicals or messages sent from the brain. Some doctors encourage their patients simply to spend time each day visualizing themselves as becoming healthier and regaining their old levels of ener and activity. Frequently this sort of mental exercise seems to speed up recovery. It should never, howeve be seen as an alternative to proper medical care but rather as a supplement to that care.

3. Answers will vary depending on the family members selected. Depending on the person you chose, you might have ideas for diversion as follows:

   - Take up a new hobby, for example, needlework, drawing or painting, stamp or coin collecting, woo carving.
   - Read books—perhaps trying different categories that you might never have tried before (mystery, science fiction, biographies).
   - Undertake a serious study of some topic that interests you.
   - Learn a new language.
   - Do crossword puzzles.
   - Develop computer skills.
   - Surf the Internet/join chat rooms or e-mail friends.
   - Listen seriously to music of different types and see what you can learn.
   - Play video games.
   - Watch TV.
   - Play card games.
   - Spend time with a small child or baby.
   - Work on sorting and cataloguing things like photos, sports cards, or recipes.

   What else did you think of?

Answers will be personal. Each person's response to grief is different; it affects people psychologically, socially, and physically. Psychologically, some of the emotions you may have felt are

- loss
- anxiety
- confusion
- sadness
- lack of interest in life
- fear
- guilt
- longing
- emptiness

The social effects of the death of a loved one are, of course, the result of your emotional response. Perhaps you felt restless and irritated by other people's seemingly trivial conversation. Perhaps you ceased to be interested in life's daily round of activities. If so, you possibly withdrew from others and wanted to be alone. Conversely, you might have sought out the company of other people more than ever so as to blot out the pain you were suffering. It can be good to be alone at times like this, but not all the time. And immersing yourself in a never-ending round of social engagements can prevent you from working through the grieving process.

The physical effects of grief often include

- a lack of energy
- sleeping and eating problems
- weakness
- a tightness of the chest and stomach
- tiredness
- shortness of breath
- a tendency to cry frequently

Grief can weaken the body's immune system, making you more susceptible to sickness. At times like this, it's important to look after yourself, though it's often difficult to do so.

If grief over the death of a family member or friend has left you unable to cope properly with life, consider seeking counselling. Many people find that support groups consisting of individuals who have experienced similar losses are especially effective in helping them get back on their feet.

5. a. Disagree. Caregivers must also be concerned with the emotional health of care receivers. A positive attitude can help the care receiver emotionally, and this can speed up recovery. Depression, by contrast, can negatively affect the body's ability to recover.

b. Disagree. All family members should become involved in care giving in order to spread out the load and create the best possible environment in the home for a speedy recovery.

c. Agree. Diversions relieve boredom and take the patient's mind off his or her illness.

d. Disagree. Rehabilitation should be started much earlier to halt the destructive process of the illness and speed the repair of bodily damage. Muscles need exercise to maintain their strength; therefore the rehabilitation process should begin as early as possible.

e. Agree. According to Dr. Kübler-Ross, people with terminal illnesses will go through a stage of anger—at the disease, at God (if they're believers), at their health-care professionals, and even at family members caring for them. This is natural and predictable.

Section 1: Activity 3

1. Answers will vary. The following list contains a few things that a teen-aged high school student might ha to adjust. An adult would, of course, have a rather different list.

    - your classes and homework
    - school trips, activities, and related commitments
    - practice times for things like sports or music rehearsals
    - participation in clubs or recitals
    - your social life with friends
    - part-time job schedules
    - time for personal fitness
    - appointments for doctors, dentists, and so on
    - time for shopping and errands
    - sleep

2. Answers will vary. Here are a few ideas you might have suggested:

    - Politely discuss the complaints and criticisms with the care-receiver to see if you can solve the problem between yourselves.

    - Seek out people, organizations, friends, and family members who can help you. You need time to yourself to regain confidence and assurance and to get your sense of perpsective back.

    - Remind yourself that the care-receiver is in a stage of learning to accept and cope with the illness. Exercise patience, but avoid getting depressed or drained of emotions.

    - Try to discover the things that seem to trigger the care-receiver's complaints and avoid doing then unless they are necessary care-giving tasks.

    - Plan diversions; bear in mind that the ill person may have nothing to look forward to and may be bored.

    - Simply develop a thick skin. Remind yourself that the fault isn't yours and just don't let the complaints get to you.

    - If all else fails, try to find alternative arrangements for looking after the patient.

    Did you come up with any other ideas?

3. Answers will vary. Here are a few ways in which you might have reacted:

    - feeling angry or betrayed
    - feeling confused, and perhaps even guilty
    - feeling overwhelmed with all the problems
    - feeling stupid or incompetent
    - accusing or laying blame
    - being rude and yelling
    - refusing to listen

4. Answers will vary depending on where you live. Here are a few agencies and organizations that you might have discovered:

- your local community-health unit
- the social-work staff of your community hospital(s)
- day centres and programs at long-term care facilities
- paid or volunteer companion services
- community meal programs
- the recreation department for programs targeted at people coping with special needs
- seniors' lodges
- community service groups for volunteers
- private, for-profit, agencies

Did you come up with other organizations?

5. a. Answers will vary. Here are a few areas where you might have appreciated help. Perhaps you thought of other ideas.

- arranging a safe, comfortable room for the ill person
- training in medical techniques for taking vital signs and giving medications
- training or help in aiding the patient with personal hygiene tasks
- cleaning the house and laundry
- scheduling appointments
- fixing meals
- shopping for groceries or medical needs
- creating diversions to entertain the ill person

b. Answers will vary. At the very least, you were likely able to acquire some booklets and fact-sheets on home care. If you managed to speak briefly with someone involved in the home-care program, you should have acquired a good deal more information—information that should help you as you work through this course. The Alberta government has a brochure entitled *Seniors Benefits* available through Alberta Seniors Benefits that lists the benefits available to seniors. You, as a caregiver may need to access some help for your care-receiver from them, especially if there are financial concerns.

6. Answers will vary. Compare your three important concerns with the ones that follow:

- receiving adequate information, training, and instruction
- getting adequate support from health-care professionals and community resources
- feeling appreciated, included, and satisfied with the role of caregiver

7. Answers will vary. Here are a few ideas to compare with your own.

RIGHTS AND RESPONSIBILITIES OF CAREGIVERS

Rights	Responsibilities
• the right to support from family members	• the responsibility of discovering and using support available in the community for the care receiver
• the right to time and energy needed for personal interests and activities	• the responsibility of working with health-care professionals to ensure quality of care
• the right to terminate the home-care situation if it proves overwhelming	

8. As with the first chart, answers will vary. Compare your ideas with the ones that follow.

RIGHTS AND RESPONSIBILITIES OF CARE-RECEIVERS

Rights	Responsibilities
• the right to have your wishes considered in respect to the care you're receiving • the right to be kept informed of any changes in your condition • the right to be helped in scheduling and attending medical appointments • the right to have medications administered as prescribed	• the responsibility of limiting demands placed on the caregiver to what is reasonable under the circumstances • the responsibility of maintaining as positive and pleasant an attitude as is reasonably possible

9. Answers will vary. Traditionally, this role has fallen most often to the woman, often the wife and mother, in the household, partly because women have traditionally been seen by society as caregivers and partly because running the household has been viewed as essentially a woman's job. And, of course, at a time when women generally stayed home, it was natural that this role would fall to them. Now things aren't this cut and dried, and every family undertaking the responsibility of home care must decide who the principal caregiver will be. Because of the degree of responsiblity, the role should be taken by an adult, and most often it's still an adult female family member who assumes it.

Section 1: Activity 4

1. This is a complex issue, isn't it? There's certainly no right or wrong answer; different people will support different solutions, and can likely make a good case for their ideas. Of course, ultimately anyone deciding this issue would have to be far more familar with it; but given the few facts you've been given, here are three typical answers to compare to your own:

   - I'd advise Mrs. Kabaroff to find a good long-term care facility nearby that's equipped to handle people with her husband's problems. Obviously Mrs. Kabaroff can't continue, and her husband will soon get used to his new home. There, he'll be cared for by professionals, and his wife and children can visit as often as they want.

   - Institutions like long-term-care facilities can be expensive, and I don't know what the Kabaroffs can afford. I think the best solution would be for those adult children to do more to help their mother out. That way, she could get away from her husband more often and get back part of her own life. One thing is clear: she can't keep this up alone.

   - I think Mrs. Kabaroff is one of those people who thinks the world will fall apart if they don't look after everything themselves. What she should do is hire someone to come in a couple of days a week—a nurse or someone—to spell her off. She should also let her children help out more. Maybe she should also join a support group or get counselling. She certainly has to lighten up and make some changes or she's going to need help for herself.

Answers will vary. Here are a few suggestions:

- Use the Internet to find information on home care, the illness itself, and support groups.
- Make sure you maintain contact with your friends and get out of the house.
- Don't let your home turn into a hospital, where everything centres around the ill person. The patient will do better if it retains its atmosphere of family life, and people will visit more often if the setting is positive and uplifting.
- Monitor yourself regularly. It's easy to slip into a depressing routine that robs you, your family, and your care receiver of life and energy.
- Don't forget the other members of the family. Your spouse and children need you too.

Answers will, of course, vary depending on who you are and precisely what the situation is. Here's one student's list with which to compare your own:

- doing errands
- doing homework/studying
- making phone calls or visiting with people I sometimes have trouble seeing now
- reading
- working on hobbies and taking up new ones
- practising the piano (or any musical instrument)
- taking up a new study—for instance, learning Spanish
- going online to learn more about the home-care job I'm doing

There are several related reasons. Here are the main ones.

- So much time and energy can be taken up with looking after the person that there isn't enough left over for maintaining friendships.
- Your life changes so much that you can no longer do the things you used to with friends, and they slip away.
- You may lose interest in other activities you enjoyed with friends if you give all your attention to the care you're giving.
- Your home may, if you aren't careful, come to be a rather depressing place for others to visit.
- Old friends of the care-receiver may become uncomfortable, and their visits can become something they do out of duty rather than for pleasure. From here, it won't take long for many of them to stop visiting as often, or stop visiting altogether.

Answers will vary. Most people who have looked after a family member for even a few days report that it was far more tiring and time-consuming than they had thought it would be. While they are usually glad to be able to help, many people find that they quickly become annoyed at the restrictions caring for another can put on their own activities. Sometimes they even become jealous. If the care-receiver becomes bored and irritable, or, even worse, slips into the "patient" mode and expects constant attention, the result can be resentment and even anger towards the caregiver. And, of course, if the situation continues for months, or even years, naturally tensions can increase enormously.

This is not to say that caring for others is an entirely negative experience; it's usually far from that. But there are often negative aspects that are easier to deal with if you anticipate them in advance.

Extra Help

1. a. False. People with acute conditions need the immediate care of health-care professionals such as doctors and nurses.

   b. True.

   c. False. Anyone can be an appropriate candidate if conditions warrant it and the resources are available in the home.

   d. False. Some costs will likely be borne by the family while other services and equipment will be provided free of charge or at reduced cost (but note that the amount and type of free services availab is subject to change).

   e. True.

   f. True.

   g. False. The term *respite care* is normally used for the relief needed by primary caregivers.

   h. True.

2. According to Dr. Kübler-Ross, the five stages are

   - denial
   - anger
   - bargaining
   - depression
   - acceptance

3. Answers may vary somewhat. Here are some possiblities.

   - The primary caregiver has the training and resources needed.
   - The primary caregiver is able to maintain mental and physical well-being.
   - There are open communications all around.
   - There is adequate support for the family.
   - The primary caregiver feels involved and comfortable with the situation.

4. Answers may vary. Your list should look basically like this one. The caregiver is responsible for

   - knowing the names and location of physicians who are treating the care-receiver

   - knowing the care-receiver's health history and any conditions such as
     - allergies
     - record of hospital treatments
     - past operations
     - current medications

   - administering medications as prescribed

   - telling the physician, health-care worker, or both about any changes in the care-receiver's health

- understanding the health problem as much as possible
- being honest and direct about anything relating to the care of the care-receiver
- helping the care-receiver to keep scheduled appointments or notifying those involved if changes must be made
- working together with the health-care workers assigned to the case

Enrichment

1. There is no suggested answer for this question, but if you were able to spend some time surfing the net, you were very likely surprised at how much information there is out there on home care related issues. This shows how important home care is becoming in the area of health care.

2. a. This refers to disparities in funding that the different provinces provide for home care. For instance, in British Columbia, whatever professional health care is needed by home-care recipients will be paid for by government, whereas in Prince Edward Island, the government will pay for no more than 28 hours a week. Later in the article, we are told that Ontario will fund this kind of care up to a ceiling of only 60 hours a month.

   b. Poorer people can get government subsidies to pay for much of the home care they need, while wealthier people can afford to pay for home care. It's therefore people caught in the middle who suffer most.

   c. (1) According to Statistics Canada, 90 percent is provided by family members.
   (2) Approximately 2.1 million Canadians are caring for senior relatives.

   d. The difficulty is that so many caregivers have jobs and children of their own. They simply don't have the time or energy for eldercare.

   e. Mr. Lightman likes the idea of home care because it costs far less than institutionalizing elderly people, and it's a more humane way of looking after people than placing them in long-term care facilities.

   f. The thinking of the National Forum on Health is that home care allows elderly people to go on living in familiar surroundings until the last stages of physical decline. It's less expensive than institutional care, and it's more emotionally satisfying for both the elderly care-receivers and their families (as long as there's sufficient support from visiting health-care professionals).

   g. Answers will vary. The article certainly stresses the advantages of home care as a method of dealing with our aging population, so chances are that after reading the article you feel this way as well. Perhaps, however, you have other ideas. Either way, were you able to support your stance with reasons and arguments?

Section 2: Activity 1

1. a. Answers will be personal. Don't worry if you answered no; most people aren't this careful (though you should still make an effort to wash your hands thoroughly). Caregivers, however, do have to take special precautions.

   b. Again, answers will vary. Most people don't wash their hands as often as they should. The fact is that almost nothing works as well as frequent, thorough hand-washing to stop the spread of everyday germs (like cold viruses).

2. Answers will vary. One student thought of these ideas:

   - Keep the floors and other surfaces (such as table tops) clean.
   - Keep the air in the room fresh and circulating. Open windows when possible.
   - Keep the care-receiver clean. Especially help wash the care-receiver's hands regularly.
   - Keep the bathroom used by the care-receiver clean.
   - Change the care-receiver's clothes/pyjamas frequently.

   Did you think of any other ideas?

3. a. Disagree. (Soiled dressings should be disposed of in a plastic bag as the discharge on the dressing ca soak through a paper bag.)

   b. Agree.

   c. Agree.

   d. Agree.

   e. Disagree. (You should wash your hands at the beginning of the process, after removing the old dressing, and after finishing the process.) Handwashing is one of the most effective ways there is to prevent the spread of infection.

4. a. If the care-receiver is feeling chilled but isn't running a high temperature and doesn't have poor circulation, a heat application is probably appropriate. Add more blankets and place a heating pad or hot-water bottle on the patient's back or at her feet. The heat will improve circulation and conduct warmth to the body.

   b. In this case, a cold application is appropriate. An ice pack, a very cold compress, or even a bag of frozen vegetables should be put on the ankle to reduce pain and swelling, but not directly on the skin

   c. If you don't know the cause of the pain, neither a heat or cold application is appropriate. You could en up aggravating the situation.

   d. If the purpose is to relieve tension and relax sore muscles, a heat application is most likely appropria

5. Answers will vary. Your pulse rate varies considerably during the day, speeding up when you're active or tense and slowing down when you're quiet and relaxed. A normal rate for an adult is somewhere between 60 and 90 beats per minute, though a child will likely have a faster rate.

6. a. Answers will vary. No doubt, you noticed some variation depending on how active or quiet you were. Did you have trouble breathing naturally?

   b. The variation would depend essentially on your degree of activity. Respiration naturally increases during activity as the body requires more oxygen.

7. In a way this is a trick question since in actual fact there is some variation in people's normal body temperature. The figures usually given are 37 degrees Celsius for an adult and 37.5 degrees Celsius for a child, but this can vary. Most adults' normal body temperature is somewhere between 36.1 degrees Celsi and 37.2 degrees Celsius. It's important to establish the normal temperature for a care-receiver so you ca tell if there's any change. Note that a drop in temperature can be just as serious as an elevated reading. Note, too, that the reading from a rectal thermometer will usually be slightly higher than that given by a oral thermometer.

8. a. Disagree. (A fever can help a body fight an infection; therefore a slight fever should be monitored and normally left alone. It should be brought down only if it gets too high; this is especially important in the case of a child.)

   b. Disagree. (Normal temperatures vary somewhat; see the suggested answer to question 7.)

   c. Disagree. (Cold cloths will work, but they can chill the patient and create a good deal of discomfort. It's better to use cloths that have been immersed in lukewarm (tepid) water.

   d. Agree.

   e. Agree.

   f. Disagree. (A mouth full of broken glass and alcohol or mercury, as were the older glass thermometers, is definitely not a recommended part of home-care therapy.)

9. There is no suggested answer for this question, but since practice is really the only way of acquiring skills like those discussed in this activity, it's a good idea to become familiar with taking people's temperatures.

Section 2: Activity 2

1. There is no suggested answer for this question. Were you suprised at how difficult it is moving a helpless bed patient?

2. There is no suggested answer for this question. Here are a few more things to remember when helping a patient in situations like these. They'll help you avoid muscle strain.

   - Wear comfortable, low-heeled shoes.
   - Stand straight, with your knees slightly bent.
   - Keep your feet about 30 cm apart.
   - Stand as close to your patient as possible.
   - As much as possible, use your leg and arm muscles rather than your back.
   - Get help if the patient is heavy.

3. Again, there is no suggested answer for this question. As noted in the activity, it's difficult to get a feel for the difficulties in this manoeuver with a "patient" who is only pretending.

4. a. Disagree. (The patient should stand for a few moments to become stabilized; otherwise, it's likely that the patient will lurch and possibly fall.)

   b. Agree.

   c. Disagree. (The patient should feel the seat of the chair with the backs of both legs.)

   d. Disagree. (Certainly the chair shouldn't be placed so that the patient will likely stumble over it, but it should be as close as possible so the patient can get access to it easily.)

5. The approved method is to put both crutches side-by-side in an upright position, with the rubber tips firmly planted on the floor. The patient should hold both crutches by their grips in one hand while positioning the other hand to push off from the bed. Then the patient should stand up, pulling up with the hand on the crutches while pushing up from the bed. Once upright, the patient should wait a few moments to become stable, and then separate the crutches and position them under the arms so as to be able to walk.

6. It's not that easy, is it? Of course, it's much, much harder when movement is painful or severely restricted. It's likely that you had the most difficulty with getting pants and underwear up and around the buttocks and reaching your feet to put on socks and shoes. Trying to wiggle into a pullover shirt can also be tricky, especially if you can't sit up.

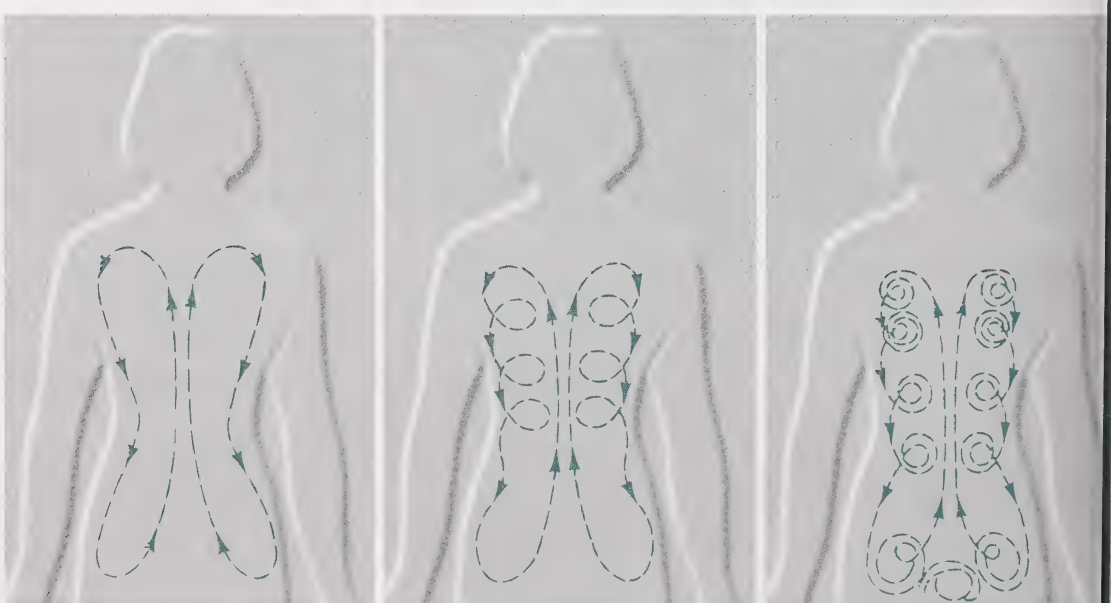
7. Answers will vary. Here are five exercises frequently prescribed for cases like these:

   - pointing the toe downward and then bending the foot back in the opposite direction, toward the body
   - with a pillow under the knee, lifting the foot in the air and putting it down
   - sliding the foot up toward the body by bending the knee (This is a hard one at first for people with this sort of injury; putting a slippery surface like that of a plastic garbage bag under the foot will help.)
   - with the leg straight, moving the foot to the side and then back
   - moving the toes together until the big toes touch and then rotating the feet away from each other

   Over and above these things, a patient confined to a bed should be doing other exercises of a more general nature to keep the body moving and comfortable. Here are a few possibilities:

   - exercises for the head and neck: moving the head up and down and from side to side
   - exercises for the arms: stretching the arms outward from the body and doing rotations of the whole arm and the wrists (with or without small weights)
   - exercises for the lungs: doing deep-breathing exercises, inhaling through the nose

8. Did you find the technique effective? Here are a few more basic back-rub patterns for you to try.



9. Massaging the hands and feet of bed patients can be an important aspect of caring for them. Foot care is especially important for older patients experiencing poor circulation, dry skin, or both. Foot, arm, or hand massages will improve circulation and relieve some of the stiffness a care-receiver may be experiencing. Massaging hands and feet also gives the caregiver an opportunity to check for minor injuries or infection.

   If you're caring for an elderly patient or someone with poor circulation, you may carefully file the toenails when you do a foot massage. (Be careful not to break the skin on the toes.) Remember to keep the sheets loose around the feet to minimize any pressure on them.

Section 2: Activity 3

1. There is no suggested answer for this activity. If you have access to the Internet, did you move around in the website to see what you can learn? Did you test yourself with the activity called Your Healthy Eating Scorecard? If you'd like to learn a bit more about Canada's Food Guide, check out this site as well.

   - **http://www.nms.on.ca/canada.htm**

   While you're there, see if you can decode the secret message after clicking on the box that says "Be a Food Group Sleuth."

2. Answers will vary somewhat. Here are a few ideas with which you can compare your own:

   - dairy products like milk, yogurt drinks, and eggnog
   - strained fruit juices
   - strained or creamed soups
   - meat or vegetable broths
   - tea and coffee
   - carbonated beverages
   - foods blended to a liquid consistency (strained if necessary)

   Did you come up with any other ideas?

3. Answers will vary. Were you as honest as you could be? Do you think you should make any changes? If so, don't make too many at once; your chances of success will be improved if you change your diet a little at a time.

4. Answers will vary. Compare your ideas with these:

   - Make sure the tray is clean.
   - Use an attractive tray cover and table napkins.
   - Use a variety of (clean) dishes.
   - Try to include an element of surprise—for example, a small flower, a cartoon, or a saying for the day.
   - Garnish the meal with parsley sprigs, carved radishes, or orange slices.
   - Provide condiments, such as salt, pepper, and sugar, in attractive containers.
   - Provide a food treat—something the care-receiver enjoys.
   - Vary your meal styles and the manner in which you serve them.
   - Try to use cheerful colours in selecting dishes, food, and napkins.

   Did you come up with any other ideas?

5. a. Were you surprised at the problems you encountered? Eating or serving food in bed can be difficult to do neatly and comfortably, and the problems are greatly compounded when the care-receiver has difficulty sitting up, chewing or swallowing, or eating independently.

   b. Were you surprised at the frustrations you felt? Most people think of eating in bed as a luxury, but for care-receiver with a disability, it can be a very difficult experience indeed.

Section 2: Activity 4

1. Answers will vary somewhat; the truth is that the best answer would depend on a specific care-receiver's needs. Room D is closest to the kitchen, and it's also near the living room, where, presumably, the family might gather until late in the evening. It's positioned best for hearing the care-receiver call, though it wou probably also pick up a lot of family noises. It's also the farthest room from the bathroom. Rooms A, B, an C are all closer to the bathroom, but farther from the kitchen and living room. Room A, with it's own entrance to the bathroom, is especially well positioned in relation to this room. Room A may also be the be choice if quietness is a consideration, but the care-receiver may be hard to hear if assistance is needed.

2. Answers will vary. Of course, just what goes into the room depends in large degree on the person to be using it. Here are a few things you might have included if the room was to be for you:

   - a television set (with, of course, a remote control)
   - a computer for games, surfing the net, or possibly working (if the patient is able to sit up and use th controls)
   - a collection of reading material within easy reach
   - a collection of videotapes
   - a wall-mounted clock within easy view
   - a telephone
   - a locked cabinet for treatment supplies and medications

   Did you think of anything else?

3. a. Answers will vary. Was it an easy decision? Did you consider all the variables? To some degree, of course, the decision couldn't really be made without considering the patient's needs. Bearing this in mind the following checklist might help with the decision:

      - Is the room near a bathroom, kitchen, and the living room or family room?
      - Is it warm, bright in colour, and cheerful? Does it admit much sunlight?
      - Can a bed be positioned out of drafts? Does air circulate freely?
      - Is the room large enough to accommodate the necessary furniture, including a comfortable cha for the patient and any guests?
      - Will the room accommodate any special equipment the patient might require?
      - Are there any dangers associated with the room (for example, stairs or raised linoleum)?

   b. Answers will vary. Was it an easy job?

4. a. bed blocks

   b. pressure pads

   c. a footboard

   d. washable or disposable pads (and, possibly, a bedside commode)

   e. taps with levers (or paddles)

   f. a bed cradle

   g. a back rest

   h. a hip roll

5. a. Answers will vary. Did you consider things like the following?

   - rugs or carpets with raised corners
   - stairs or steps up and down to different levels of the home
   - extension cords that get kicked out into the room
   - clutter (for example, newspapers, magazines, toys, or clothing left on the floor)
   - furniture that slides easily
   - spots that frequently become wet or slippery where people enter the home or leave wet boots
   - slippery bathroom surfaces

   b. Answers will depend on your discoveries when doing question a. Did you encounter any difficulties?

6. Answers will vary. Did you think of a particular friend's home, or did you simply make a list of generic suggestions? Here are a few ideas you may have thought of:

   - Remove clutter and see that it stays removed.
   - Remove any rugs and mats that might slip, wrinkle, or catch someone's foot.
   - Make sure all electrical cords are lying neatly along the wall, behind furniture—not beneath rugs or mats.
   - Add sufficient lighting, especially to stairways. Use nightlights in the hallways and bathroom.
   - Make sure stairs have railings.
   - Install a railing in the bathtub or shower and put non-skid surface on the floors.
   - Rearrange furniture, if necessary, to ensure that there's room for a person and a walker to move around easily.

   Did you think of any other ideas?

7. Answers will vary. You may have considered some of these:

   - doorways leading to stairs but lacking doors (for example, basement stairways)
   - easily accessible exits in case of fire
   - handy fire extinguishers
   - if the patient suffers from dementia, the presence of knives, power tools, or other potentially dangerous items
   - pets that may lie around the house in various locations

   You may well have thought of other safety concerns.

8. Answers will vary. Did you notice that the chart makes no mention of the bedroom itself? Other aspects o home safety you might have added to the chart are electrical fixtures and wiring, safety/alarm systems (for example, smoke detectors and fire extinguishers), communications systems (for example, bells, buzzers, or an intercom system), and, perhaps, safety in the yard outside the home.

Section 2: Follow-up Activities

Extra Help

1. a. cold

   b. cold

   c. heat

   d. cold

   e. heat

   f. heat (Don't use a heating pad.)

   g. neither (A cold application will work, but a tepid one is easier on the patient.)

   h. neither (If you don't know the reason for the pain, seek a professional opinion.)

2. a. Have the care-receiver rest for at least ten minutes.

   b. Use two fingers, not your thumb, which has a strong pulse of its own.

   c. Press lightly; you don't want to cut off the circulation.

   d. Count for one minute (60 seconds) or, at the very least, for a number of seconds that easily divide in 60 so an accurate rate can be instantly worked out.

3. a. False (A patient shouldn't eat or drink anything at all, hot or cold, before having a temperature reading done.)

   b. True

   c. True

   d. True

   e. False (The mouth must be closed for an accurate reading. If a patient can't manage this, use a different method for reading temperature.)

4. Your list should look basically like the following:

   - Stand beside the bed, facing the head of the bed.
   - Lock your arm nearest the patient with his or her arm.
   - Support the patient's head and shoulders with your other arm.
   - Have the patient bend his or her knees, if possible.
   - On a count of three, pull the patient up while the patient pushes with the feet and lifts the buttocks, if possible.

   If the patient is unable to help with either leg, get another person to stand on the other side of the bed, lock arms with the patient, and pull along with you on the count of three, being careful not to 'drag' the person.

5. a. pressure pads

   b. a footboard

   c. a hip roll

   d. a hand roll

   e. a bedside commode

   f. taps operated by levers or paddles

   g. a grab bar (and, perhaps, a non-skid surface on the tiles)

6. Answers will vary a bit; but essentially, you'd be preparing meals consisting of easily digested foods plainly prepared and cooked. You wouldn't heavily spice the meals; and you'd avoid coarse, fibrous foods like raw vegetables, most fruits, coarse breads, and cereals. You'd also avoid fats, nuts, and rich pastries. In other words, you'd prepare meals that were simple, plainly prepared, and easily digested.

Enrichment

1. Naturally, there's no suggested answer for this question. Did you find the job easier or tougher than you'd expected. People working in hospitals and long-term-care facilities must perform this task routinely; it's surprising how quickly and how well they're able to make those beds.

2. Here's one student's listing of steps:

   - Make the room temperature comfortable.
   - Assemble wash basin, soap, facecloths, towels, clean clothes, lotions.
   - Remove the bedding on top of the bed except the top sheet.
   - Raise the patient to a sitting position.
   - Have the patient cleanse his or her face using the products normally used.
   - Give the patient a wet, soapy face cloth (but not too wet).
   - Have the patient wash starting with the neck and working down.
   - Remind the patient to wash small areas; then rinse and dry them thoroughy.
   - Help the care-receiver wash his or her back.
   - Have the care-receiver wash the underarm and groin areas last.
   - Make sure all skin folds are properly dried to prevent a rash.
   - Put the washcloth and the towel into the laundry.
   - Help the care-receiver put on clean clothes.
   - Help cut and file nails if necessary.
   - Help comb the care-receiver's hair if necessary.

3. There is no suggested answer for this activity. Were you supprised at the number of websites devoted to home care and being a care-receiver? It's becoming a big factor in our health-care system, and it's bound t become much more important as "baby boomers" approach their senior years.

Section 3: Activity 1

1. a. A lightly pigmented person can become pink when the capillaries in the skin become dilated (that is, they expand) to admit more blood. This increased blood in the skin creates the rosy colour associated with blushing, exercise, and warmth.

   b. (i.) A light-skinned person's skin becomes whitish when the person is very cold, eventually developing a bluish tinge.

   (ii.) This happens when blood moves away from the skin as the body attempts to prevent as much warmth as possible from escaping.

2. The three layers are, from bottom to top,

   a. subcutaneous tissue

   b. dermis (or corium)

   c. epidermis

3. Answers will vary. Compare the following ideas with your own:

   - Avoid the summer sun as much as possible, especially during the peak hours of 11 A.M. to 4 P.M.
   - Wear effective sunscreen when out in the sun.
   - Wear wide-brimmed hats and closely woven clothing.
   - Wear sun protection even on a cloudy or hazy day.
   - Be aware of sunlight reflecting off surfaces such as sand, water, and cement.
   - If you still intend to get a tan, do it slowly to minimize trauma to the skin.

   Did you come up with any other ideas?

4. The five layers are

   a. stratum corneum or flat, dead cell layer

   b. stratum lucidum or clear cell layer

   c. stratum granulosum or granular cell layer

   d. stratum spinosum or prickly or spinous cell layer

   e. stratum germinativum or basal cell layer

5. a. Answers will, of course, be personal. Many teenagers have very active sebaceous glands. Of course, it's quite possible to have more active sebaceous glands on one part of the body than another, resulting, perhaps, in dry hair but an oily forehead or acne on the face but dry hands.

   b. Answers will be personal. Most people find that their skin is drier in winter than summer. This is especially true in dry, cold climates like Alberta's.

6. a. sebaceous glands

   b. apocrine sweat glands

   c. eccrine sweat glands

   d. hair

   e. nails

   f. vellum hair

7. Piercing her nose should cause less discomfort because the nose has fewer pain receptors than the forehead. If Jan is really worried about pain, however, she should limit herself to pierced ears, where there are even fewer receptors.

8. Your advice should be that your friends should give up trying to look tanned and, instead, protect themselves from over-exposure to the sun. Tanning salons, also, are generally not recommended. It's an interesting historical note that until the last few generations, fair-skinned people actually prided themselves on not being tanned. A suntan was regarded as an indicator of hard, manual, outdoor work whereas a pale skin was thought to show a life of leisure or at least an indoor job that required education. A pale skin was, then, thought to show education, breeding, wealth, and a relatively high social class.

   Nowadays, of course, things have changed. A tan is thought to indicate a healthy life and enough leisure time to lie on beaches. A winter tan is even better; it shows enough wealth to take winter vacations in warmer climates. By contrast, a pale skin indicates someone chained to the desk.

9. Don't panic if you have many moles; many people do. However, it's wise to check yourself over now and again to make sure that they're all behaving normally. Note that a normal mole is round or oval and even in colour. By contrast, a mole that starts to grow, develops a new or contrasting colour (black, brown, red, blue, or white), and/or has an irregualr shape with a border that's scalloped but well defined, should be looked at by a doctor.

Section 3: Activity 2

1. a. Answers will be personal. Many teenagers do experience these things to some degree.

   b. Answers will vary. Many people wash their faces frequently and/or use special cleansing agents and creams. Others watch their diets, avoiding rich, greasy food in favour of more wholesome fare. Certainly keeping clean and eating healthily are always good ideas for anyone of any age, and proper antiseptic medications may help acne. But since the real culprit is the hormone androgen, these methods won't likely be entirely successful. Anyone with severe acne should consult a doctor; others, experiencing a few pimples typical of adolescence, should simply accept them and follow normal hygiene practices, but keep an eye out for any changes that might require medical attention.

2. a. psoriasis

   b. plantar warts

   c. boil

   d. seborrhea

   e. eczema

   f. athlete's foot

   g. impetigo

3. There is no suggested answer for this question.

4. Using the rule of nines, this patient has burns to approximately 37 percent of his body. The breakdown is as follows:

• right arm	9 percent
• lower torso, front	9 percent
• lower torso, back	9 percent
• groin	1 percent
• half right leg	9 percent
Total	37 percent

5. a. second-degree

   b. third degree

   c. second degree

   d. first degree

6. You should have told Nicholas's mother not to break the blisters or to pull away the skin. As well, you should have advised her not to apply antiseptic creams and to raise her son's leg rather than lower it. In fact, Nicholas's mother did absolutely everything wrong.

Section 3: Activity 3

1. a. wheal

   b. vesicles

   c. macules

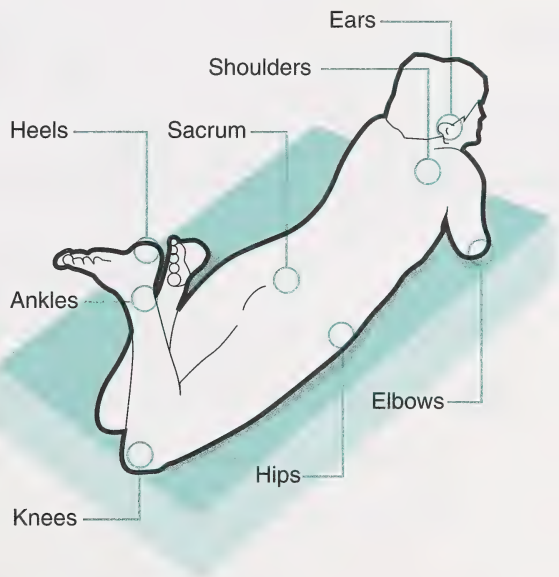
   d. excoriations (originally wheals)

   e. pustules (or, possibly papules)

2. Mrs. Carruthers has done almost everything wrong. Her mistakes are as follows:

   - She made the water hot instead of tepid.
   - She didn't take the time to explain what was going on and to reassure her mother.
   - She left her mother alone.
   - She left her mother in the bath at least half an hour too long.
   - She let the water cool down, chilling her mother.
   - She dried her mother off by rubbing her with a coarse towel instead of gently patting her.

3. Answers may vary somewhat, but this diagram shows the most common sites for pressure sores.



4. Here's the list of measures as it appeared in Section 2: Activity 2:

   - Make sure the bed sheets are clean, dry, and smooth.
   - Change the patient's pyjamas or clothing whenever it becomes soiled or wet.
   - Wash the patient's skin regularly and keep the areas between the folds of the skin clean and dry.
   - Massage the patient with creams or lotion regularly.
   - Use pillows, pieces of sheepskin, and sponge foam to protect the pressure-bearing areas.
   - Make sure the patient drinks enough fluids and maintains proper nutrition.
   - Help the care-receiver with exercises to improve circulation.

5. a. It has reached Stage 3.

   b. The area around this sore should be regularly massaged, but not the sore itself. It should be kept clea and dry, and covered by special dressings. The sore should be monitored and assessed frequently. It should probably be washed regularly with special cleansers, and assorted ointments may be used to remove dead skin and promote the growth of healthy tissue. It's possible that bathing in a whirlpool bath would help.

6. There is no suggested answer for this question.

Section 3: Follow-up Activities

Extra Help

1. The three layers are

   - the epidermis
   - the dermis (or corium)
   - subcutaneous tissue

2. a. 1) C
      2) D
      3) E
      4) B
      5) A

   b. The correct order is

      - stratum corneum (flat, dead cell layer)
      - stratum lucidum (clear cell layer)
      - stratum granulosum (granular cell layer)
      - stratum spinosum (prickly cell layer, or spinous cell layer)
      - stratum germinativum (basal cell layer)

3. The two appendages are

   - hair
   - nails

4. The skin's exposure to sunlight allows the body to synthesize vitamin D, an essential nutrient.

5. a. plantar warts
   b. psoriasis
   c. impetigo
   d. a malignant melanoma
   e. a blackhead

6. a. Approximately 9 percent of his body surface has been burned.

   b. These are third-degree burns.

   c. You should get Harrison to the hospital immediately. Meanwhile, you should check to see that he isn going into shock. If he is, you should keep him warm (but not hot) and have him lie down (with his arm elevated if possible). You should stay with him, and keep an eye on his pulse.

7. Answers will vary somewhat. Your list should include at least six of the following points:

- Make sure the bed sheets are clean, dry, and smooth.
- Change the patient's pyjamas or clothing whenever it becomes soiled or wet.
- Wash the patient's skin regularly and keep the areas between the folds of the skin clean and dry.
- Massage the patient with creams or lotion regularly.
- Use pillows, pieces of sheepskin, and sponge foam to protect the pressure-bearing areas.
- Make sure the patient drinks enough fluids and maintains proper nutrition.
- Help the care-receiver with exercises to improve circulation.
- Run a thorough check of the skin daily.
- Every opportunity you're given while working with a patient, check over spots on the patient's body where pressure sores are likely to occur.
- Change the position of the patient every two hours. Make sure this is a real change, so the pressure points shift, but avoid friction during the process.
- If a patient is incontinent, remove any urine or feces from the skin as soon as possible.
- Watch out for hard objects like crumbs in the bed.
- Position equipment or tubes so they don't rub or create pressure.
- Massage around any reddish areas with a rubbing lotion, but not directly on the site (and don't use alcohol).
- Don't apply lotions to any open sores.
- Use cornstarch on friction areas, but only a dusting. Don't let it cake up.
- At least twice a day, have the patient do exercises to improve circulation.

Enrichment

. a. (1) wheals
(2) vesicles
(3) macules
(4) papules or pustules
(5) bullae
(6) furuncles
(7) papules

b. The lesions should be classified as follows:

Primary	Secondary
• tumour	• scale
• macule	• crust
• papule	• excoriation
• bulla	• fissure
• wheal	• scar
• pustule	

2. to 4. There are no suggested answers for these questions; but if you did all or any of them, you should have improved your knowledge and understanding of skin disorders while developing your research skills.

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